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Therapists' Attributions Of Blame Toward Victims Of Incest

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Abstract

THERAPISTS' ATTRIBUTIONS OF BLAME TOWARD VICTIMS OF INCEST

Therapists (N = 202) read vignettes describing families in which: (a) incest has occurred; (b) a child has been abused physically; (c) a child has been diagnosed as having Attention Deficit Disorder with Hyperactivity; and (d) a child has been diagnosed as having schizophrenia. After reading each vignette, responding therapists used semantic differential rating scales to rate the child, the father of the child (who was the perpetrator of the incest and the physical abuse), and the mother. Therapists also completed scales measuring the personality dimensions of empathy and locus of control, and a series of questions concerned with their background and training.

Factor analysis of the semantic differential ratings yielded a factor measuring attribution of blame. Therapists attributed more blame to the perpetrator of incest and to the mother of the victim than they did to the victim. It was anticipated that male therapists would tend to attribute more blame to a female victim than to a male victim, while female therapists would manifest the opposite pattern. This anticipated result was not obtained. Rather, both male and female therapists placed greater blame on a male victim than on a female victim.

Therapist empathy was related negatively to the tendency to blame the victim. Locus of control was not related to attribution of blame. More experienced therapists, those reporting experience working with victims of sexual abuse, and therapists who had coursework on incest were less likely to blame the victim. Results were interpreted in terms of implications for psychology, social work, and family therapy education.

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Dedication

This dissertation is dedicated to Dr. Philip R. Geron and Douglas, Eric, Laura, Scott, and Emily Geron, whose love and support keep me strong.

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Chapter I

Introduction

The study presented here was designed to determine the extent to which therapists working with victims of incest tended to attribute blame to the victims, the perpetrators, and the victims' mothers. An additional purpose of the study was to determine the relationship between attributions of blame and several therapist characteristics, including gender, years of clinical experience, extent of experience dealing specifically with cases of incest, level of education, prior exposure to coursework and/or inservice education concerned with incest, empathy, and locus of control. The section that follows indicates the rationale for carrying out this study at this point in time.

Theoretical Rationale

The rationale for this study was based on the following five premises, each of which will be documented in the subsections of the rationale that follow.

Incest is not a rare event in our society, but is rather quite common (Finkelhor, 1994; U.S. Department of Health & Human Services, 1995).

A history of incest is predictive of a number of serious psychosocial adjustment disorders which often persist into adulthood (Cole & Putnam, 1992; Davidson, Hughes, George, & Blazer, 1996; Green, 1996).

These disorders appear to be associated with difficulties among victims of incest in the areas of the development of an integrated sense of self and the maintenance of satisfying interpersonal relationships. Given these dynamics, one would suspect that psychotherapy would be extremely beneficial to incest victims, both immediately following the disclosure of the incest and in the long-term (Frenken & Van Stolk, 1990).

However, victims of incest who are involved in psychotherapy tend to report

dissatisfaction with treatment processes. Specifically, patients often experience their therapists as judgmental, attributing at least some of the blame for the incest to the victims themselves. There is also some evidence that attributions of blame on the part of the therapist may induce guilt in survivors, and that these feelings may interfere with a survivor's satisfaction with the therapeutic process (Evans & Sullivan, 1995).

Existing theory and research suggested that the degree to which survivors experience therapists positively may vary with the therapists' gender, clinical experience, training, empathy, and locus of control (Evans & Sullivan, 1995). This leads one to suspect that these variables may also be related to the therapist's tendency to attribute blame. However, these propositions have not yet been tested directly. The study proposed here was designed to address the lack of available empirical evidence with respect to these relationships. The sections of this chapter that follow support each of these propositions.

The Prevalence of Incest in Our Society.

Hussey and Singer (1993) have defined child sexual abuse as any sexual experiences which occur between children under the age of 16 and individuals who are 5 or more years older. Sexual experiences include oral-genital contact, genital or anal penetration, genital touching of the victim by the perpetrator, any other touching of private parts, or sexual kissing or hugging. Also encompassed within the category of sexual experiences are sexual staring at the victim by the perpetrator, accidental or disguised touching of the victim's body by the perpetrator, verbal invitations to engage in sexual activity, verbal ridiculing of body parts, pornographic photography, reading sexually explicit material to children, and exposure to inappropriate sexual activity.

The U.S. Department of Health and Human Services (1995) reported that there were 142,537 documented cases of child sexual abuse in 1993. Other investigators have suggested that the actual number of instances of child sexual abuse each year is closer to

200,000 (Finkelhor & Hotaling, 1984). The Administration on Children, Youth, and Families of the U.S. Department of Health and Human Services Administration (2002) estimated that 43 % of children who experience sexual abuse are abused by family members. Most research indicates that girls are substantially more likely than boys to become the victims of incest. Green (1996) estimated that three out of four victims of child sexual abuse are girls.

Moreover, it seems clear that incest is a grossly underreported crime (Bagley & Ramsey, 1986; Russell, 1983; Wyatt, 1985). There are several reasons for this. Green (1996) cited the prevalence of denial among incestuous family members:

> The father denies and rationalizes the sexual contact with his daughter as 'sex education.' The mother cannot accept the incest as a reality because to do so would jeopardize the highly dependent relationship she has with her husband...The child's denial of the incest experience permits her to maintain the fantasy of having normal parents and preserves the equilibrium of the family. (pp. 76-77)

Beyond denial, victims are likely to experience significant pressure not to reveal the incest. The victims are likely to feel such pressure not only from the perpetrator, but also from mothers and other family members (Brunngraber, 1986; Finkelhor, 1995; Morrison & Clavenna-Valleroy, 1998). Incest involving male victims may be even more underreported than father-daughter incest, because of the stigma associated with the homosexual connotations of incest involving male perpetrators and male victims.

Psychosocial Adjustment Sequellae of Child Sexual Abuse

The literature was quite clear with respect to the symptoms experienced by victims of child sexual abuse in general and victims of incest in particular. Incest

survivors often experience post-traumatic stress disorder (PTSD), which manifests itself in amnesia, flashbacks, and nightmares (Green, 1996).

However, the long-term effects of incest appear to be equally profound. Adult survivors of incest have been shown to be at heightened risk of the following psychological symptoms and psychosocial adjustment problems: (a) suicidal ideation and suicide attempts (Davidson et al., 1996); (b) borderline personality disorder (Harney, 1992); (c) internalizing disorders including anxiety, depression, and substance abuse (Friedrich, Urquiza, & Beilke, 1986; Kearney-Cooke, 1988; Livingston, 1987); (d) low self-esteem (Hotte & Rafman, 1992); (e) impaired social relationships (Adams-Tucker, 1982; Sgroi, Blick, & Porter, 1982); (f) poor parenting skills (Cole, Woolger, Power, & Smith, 1992); (g) dissociative symptoms, including multiple personality disorder (Coons & Millstein, 1986; Goodwin, Zouhar, & Bergman, 1989); (h) eating disorders (Cole & Putnam, 1992); and (i) disturbances in sexual behavior (Bess & Janssen, 1982; Brooks, 1982; Tsai & Wagner, 1978; Yates, 1982).

Given the difficulties experienced by victims of incest, it is clear that research should be directed toward improving our understanding of the dynamics of incest survivors' pathologies and devising the most effective strategies for treating these problems.

Theory and Research on the Etiology of Incest Survivors' Pathologies

Cole and Putnam (1992) have attempted to construct a developmental model of the effects of incest on individual development. They have suggested that incest has "unique negative effects in the domains of self and social functioning, specifically in jeopardizing self-definition and integration, self-regulatory processes, and a sense of security and trust in relationships" (p. 174). Cole and Putnam argued that incest perpetrated by a father is rarely a discrete traumatic event. The incest tends to emerge within the context of broader family dysfunction.

Typically, the first sexual contact in father-incest is with the eldest daughter, and it occurs when she is between the ages of seven and nine. Regardless of the relationship of the victim to the perpetrator, the victim must deal with several different threatening aspects of the experience, including: (a) physical and psychological trauma derived from the actual sexual contacts; (b) extended periods of guilt, apprehension, and fear between the episodes of abuse; and (c) the loss of a trusting relationship with an extremely important individual.

Cole and Putnam (1992) argued that the effects of the pervasive and extended stress of ongoing incest are

> most pronounced in domains of self-development, specifically in the development of physical and psychological self-integrity, and the development of self-regulatory processes, particularly the regulation of affect and impulse control. Moreover, the development of self is integrally related to social development and a sense of others... (S)exual abuse by a parent violates the child's basic beliefs about safety and trust in relationships, disturbing both the sense of self and the ability to have satisfying relationships in which one feels loved and protected. (p.175)

Given these dynamics underlying the symptoms of incest survivors, one would suspect that psychotherapy would be particularly valuable for this population. The trusting relationship with a therapist and the supportive environment encountered in treatment might be expected to have major reparative effects on survivors' abilities to experience relationships as positive (Adams, 1996). However, the available data suggest that often this is not the case.

Dissatisfaction With Psychotherapy Among Incest Survivors

There is some empirical evidence suggesting that victims of incest tend to report significant dissatisfaction when they seek to address the issue of sexual abuse in psychotherapy. Frenken and Van Stolk (1990) reported the results of in-depth interviews conducted with 50 female incest survivors who had mentioned their histories of incest to professionals. Many of the women in this study reported that their therapists did not pursue the topic of incest once the patient had reported her experience. In the first contact the women had with a professional to whom they divulged their experiences, the women indicated that 28 (68%) of the professionals involved did not delve further into what was being told to them. Several of the women in this study indicated that their therapists asked questions suggesting that their recollections of the experience may in fact have been inaccurate or exaggerated.

Of the 50 women who participated in this study, 38 were sufficiently discontented with the first therapist with whom they consulted that they left treatment with that individual and sought consultation with a second professional. Moreover, 29 of the women consulted with a third therapist; 21 had consulted with a fourth; 12, a fifth; and 7, a sixth. Amazingly, one woman reported that she had seen nine different professionals. The average number of professionals seen by the women in this group was 3.5. Thus, it certainly does not appear that most incest survivors seeking professional help located a satisfactory therapist quickly. Many of the women in this study reported that they stopped seeking a therapist before they ever found one with whom they felt comfortable.

When the women were asked to rate the first therapist to whom they had mentioned the incest on a scale ranging from 1 (very dissatisfied) to 5 (very satisfied), 65 percent provided a response indicating some level of dissatisfaction with that therapist. On the basis of these interviews, Frenken and Van Stolk (1990) concluded that the professionals (a) tended not to detect or diagnose sexual abuse, and

(b) generally did not seek to maintain the incest as a continuing topic of discussion.

It may be argued that some therapists avoid the topic of incest in an effort to avoid being perceived as too intrusive. However, it seems axiomatic that a history of incest is clearly a topic that needs to be addressed in therapy, and one would hope that therapists would be encouraged in their training not to avoid this area. Of course, the timing of the introduction of the topic of incest is also very important, since this must occur at a point in treatment where the client feels ready to reveal the history.

It has been observed that "circularity of trust" is generally an important issue in psychotherapy with incest survivors. Victims of incest have learned not to trust authority figures, and they frequently have great difficulty developing sufficient degrees of trust in their therapists to enable them to self disclose and accept interpretation. The skill of the therapist would appear to be critical to the development of a trusting therapeutic relationship. One would assume that a competent, empathic, and concerned therapist will strive to create a therapeutic environment in which patients would feel comfortable discussing the issue.

Furthermore, Frenken and Van Stolk (1990) concluded that, even in those cases where the incest did remain a topic in the therapy, the women patients they studied still tended to be dissatisfied. According to the women interviewed, of the 61 professionals seen who did discuss the incest, 19 of them (30%) expressed disbelief, 23 (38%) minimized or belittled the impact of the experience, 19 (30%) put the blame on the victims, and 21 (34%) made light of the perpetrators' actions. In addition, the women reported that 23 of the professionals (38%) expressed astonishment at the fact that the women had remained silent regarding the incest for such a long period of time. Frenken and Van Stolk did not report the number of professionals seen who engaged in none of these behaviors. These expressions were typically interpreted by survivors as indicating a lack of understanding on the part

of the professional or as "implicit reference to their own responsibilities for what had happened" (p. 260).

Therapists' Attributions of Blame to Clients.

Thus it seems clear that the perceptions on the parts of survivors that therapists tend to attribute some or all of the blame for the incest to the survivors' own behaviors appears to have a substantial negative impact on satisfaction with treatment. This view is supported by Josephson and Fong-Beyette (1987), who interviewed a total of 37 female incest victims who had sought counseling within the previous 3 years. These women reported on a total of 47 encounters with different counselors. Of these 47 encounters, 38 included disclosures of incest, and nine involved non-disclosures.

The women who disclosed their experiences suggested that they tended to (a) believe that disclosing would make them feel better, (b) have seen or read media articles encouraging disclosure, (c) have been asked directly about possible sexual abuse by their counselors, or (d) have been encouraged by friends or relatives to disclose. The women who did not disclose were inclined to (a) report that their counselors did not ask them directly about possible abuse, (b) attribute their presenting problems to factors other than the history of incest, and (c) feel that it was more important to address other problems during counseling.

Among those women who reported disclosing their incest survivor status, reports of counselors' reactions to the disclosure ranged from quite positive to extremely negative. The positive reactions reported included (a) calm acceptance of the report, (b) encouragement to talk more about the incest, and (c) expressions of empathy and concern. The importance of the therapist's empathy and concern expressed by these women in this study provided the basis for including a measure of therapist empathy in the study proposed here. The negative reactions included

(a) clearly discernable counselor discomfort, which encompassed both verbal responses and physical manifestations of discomfort, such as distressed facial expressions and fidgeting, (b) attempts to minimize the importance or the effects of the incest, (c) excessive interest in the details of the sexual act, (d) ignoring the disclosure, and (e) expressions of anger directed at either the victim or the perpetrator.

Furthermore, the reactions of the counselors were found to be related to the clients' feelings following the disclosure. Those clients who reported positive counselor reactions tended to express feelings of relief and an increased sense of trust in the counselors. In contrast, those clients who reported that they felt their counselors attributed some degree of blame for the experiences to the survivors themselves tended also to report subsequent feelings of guilt and a lack of trust in their counselors. Many of these clients discontinued counseling, and many reported that they did not discuss their incest experiences ever again in any other venue.

Josephson and Fong-Beyette (1987) also reported that the extent to which incest survivors perceived their counselors positively was related to both the gender of the counselors and to the counselors' levels of experience and training. Female counselors were more likely to be described in positive terms than male counselors. Several of the responding survivors stated directly that they felt they could disclose their incest experiences to female counselors, but not to male counselors. In addition, a positive relationship was found between the level of experience a counselor had in working with incest survivors and the survivor's experiencing a counselor in positive terms.

It has also been suggested that clients' perceptions of therapists may be related to the counselor personality characteristics of empathy (Josephson & Fong-Beyette, 1987) and locus of control (Doherty & Ryder, 1979; Rotter, 1990). Clearly, one would expect that clients would feel more comfortable disclosing highly charged and personal information to therapists whom they perceive as empathic (Davis, 1996). Furthermore, clinical experience suggests that clients may be more likely to trust and disclose sensitive information to a therapist with an internal locus of control, since such a therapist would tend to convey a sense of confidence and the ability to actually do something to ease the distress being experienced by the client. This is particularly important in view of the fact that an essential characteristic of child sexual abuse is the feeling on the part of the victims that they are not in control, i.e., that abuse at the hands of a powerful older perpetrator will take place regardless of their wishes or their efforts to prevent it. Thus, victims of child sexual abuse may well have a tendency toward learned helplessness (Lefcourt, 1990, 1991). Therefore, a therapist with a strong internal locus of control might well serve as a positive role model in the development of a sense of personal control (Rotter, Seeman, & Liverant, 1962).

No research reported to date has reported specifically on the relationships between these counselor variables and counselor attributions of blame to a victim, a perpetrator, or the victim's mother. However, since a tendency on the part of the counselors to attribute blame for incest experiences was mentioned by survivors as one of the several possible negative reactions to counselors, it was logical to proceed to such a specific investigation of attributions of blame.

Statement of the Problem

Based on the foregoing theoretical rationale, the study presented here was designed to examine the extent to which therapists tend to attribute blame for incest to a victim, a perpetrator, and a victim's mother. In addition, the investigator sought to determine the significance of relationships between the therapists' attributions of blame for the incest and selected dimensions of the therapist's background and personality. Specifically, the study focuses on the therapist characteristics of gender, years of clinical experience, extent of experience working with victims of father-daughter incest, exposure to preservice coursework and/or inservice educational experiences focusing directly on incest, empathy, and locus of control.

Research Questions

1. What was the relationship between a therapist's gender and the therapist's attribution of blame for the incest to the victim, the perpetrator, and the victim's mother?
2. What was the relationship between a therapist's years of experience and the therapist's attribution of blame for the incest to the victim, the perpetrator, and the victim's mother?
3. What was the relationship between the extent of the therapist's experience dealing with cases of incest and the therapist's attribution of blame for the incest to the victim, the perpetrator, and the victim's mother?
4. What was the relationship between a therapist's exposure to preservice education on incest and the therapist's attribution of blame for the incest to the victim, the perpetrator, and the victim's mother?

5. What was the relationship between the therapist's level of education and the therapist's attribution of blame for the incest to the victim, the perpetrator, and the victim's mother?

6. What was the relationship between the therapist's exposure to inservice education on incest and the therapist's attribution of blame for the incest to the victim, the perpetrator, and the victim's mother?

7. What was the relationship between the therapist's measured empathy and the therapist's attribution of blame for the incest to the victim, the perpetrator, and the victim's mother?

8. What was the relationship between the therapist's measured locus of control and the therapist's attribution of blame for the incest to the victim, the perpetrator, and the victim's mother?

Chapter II

Review of the Literature

In this chapter the literature on childhood sexual abuse and incest is reviewed. The chapter has been organized under seven major headings, as follows: (a) Child sexual abuse and incest defined, (b) description of a normative incestuous relationship, (c) prevalence of child sexual abuse and incest, (d) immediate and long-term psychosocial adjustment difficulties associated with the experience of child sexual abuse and incest, (e) theoretical models of the dynamic of child sexual abuse and incest, (f) repressed memories of childhood trauma, and (g) therapist attributions of blame for incest. The chapter concludes with a summary and statement of directions for future research.

Child Sexual Abuse and Incest Defined

There are broad and narrow definitions of both child sexual abuse and incest. State laws defining these crimes vary widely from state to state (Coleman, 1984). Moreover, there is widespread disagreement among scholars from various disciplines regarding the behaviors that should be considered to represent sexual abuse, as well as the seriousness of various forms of abuse (Giovannoni & Beccera, 1979).

The competing definitions need to be understood clearly because differences in the way one defines child sexual abuse and incest can lead to confusion and misinformation with respect to both the incidence and the effects of these phenomena (Wyatt & Peters, 1986). Both child sexual abuse and incest may be defined very narrowly, as requiring sexual intercourse involving penetration. It may be defined

somewhat more broadly, as requiring physical touching but not necessarily penetration. Or it may be defined quite broadly, by also including within the definition of sexual abuse certain non-contact behaviors, such as exposure of the genitals, lewd remarks, or solicitations to engage in sexual activities.

The Child Abuse Prevention and Treatment Act of 1992 (PL 100-294) defined child sexual abuse as "the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct, or the rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children" (U.S. Department of Health and Human Services, 1992, p.24). This definition is obviously not very specific, since the definition itself contains numerous words which can also be defined in very different ways, one of which is the word incest. In addition, this definition reflects the primary focus of PL 100-294, which was to combat the production and distribution of child pornography.

Hussey and Singer (1993) provided a definition of sexual abuse which appears to enjoy some support within the field (Diaz, 1994). Hussey and Singer (1993) defined child sexual abuse as any sexual experiences that occur between a child under the age of 16 and a person 5 or more years older. While this definition is specific with respect to the age of the child and the required age differential between the victim and the perpetrator, it is also vague in its use of the term "sexual experiences."

Those concerned with the treatment of victims of child sexual abuse have tended to employ the broadest definitions of abuse, since they are concerned with any behaviors that might have an adverse psychological effect on a child victim (Meiselman, 1990).

According to Steele (1981), the essential abusive element of childhood sexual abuse is the misuse of an immature child by an adult for the purpose of satisfying the needs of the adult or solving problems that the adult may be experiencing while disregarding the needs and the developmental status of the child.

Consistent with the criteria specified by Steele (1981, 1990) is the composite definition of child sexual abuse presented by Diaz (1994). She drew upon several previous attempts to define child abuse, selecting specific aspects of each effort. Drawing upon Friedrich et al. (1986) and Friedrich (1987), Diaz suggested that "childhood sexual abuse was defined as sexual contact with a perpetrator at least six years older than the child, whether by force or consent" (Diaz, 1994, p. 8). To further specify the meaning of "sexual contact," Diaz drew upon Wyatt and Peters (1986). Diaz (1994) stated that sexual abuse may involve contact or non-contact behaviors. Contact abuse encompasses fondling, the rubbing of the perpetrator's genitals against the victim's body, attempted or completed vaginal intercourse, oral sex, and anal sex. Non-contact abuse refers to sexual behaviors that do not involve physical contact between perpetrator and victim, such as exposure of the genitals and solicitations to engage in sexual activity.

Once one has accepted a definition of child sexual abuse, the next issue to address is when such abuse constitutes incest. In this regard, Coleman (1984) noted that legal definitions of incest tend to be narrow, with the majority of state statutes limiting the criminal act of incest to sexual intercourse. Coleman noted that sexual intercourse requires penetration, and that a successful prosecution for incest requires proof of penetration. This limitation may make it difficult or impossible to obtain a conviction

under an incest statute. For this reason, many prosecutors employ laws against child sexual abuse in general instead of or in conjunction with incest laws.

Coleman (1984) also noted that in many states incest is only a crime when sexual intercourse occurs between blood relatives. Green (1996) stipulated that "the legal definition of incest is cohabitation between persons related to a degree where marriage would be prohibited by law." This legal definition excludes the prosecution of stepparents, adoptive parents, or other individuals who have assumed a parental role. Coleman noted that "psychologists, psychiatrists, and social workers define incestuous behavior more broadly" (p. 256). These workers tend to regard sexual contact between any non-married members of a family as incest. Family members who may commit incest under this definition include parents, grandparents, older siblings, other relatives, and also nonrelated adult caretakers living in the home, including stepparents and parents' paramours.

Coleman (1984) noted that in an effort to clarify the confusion surrounding the legal and mental health definitions of incest, the National Center on Child Abuse and Neglect has substituted the phrase, "intrafamilial sexual abuse" for incest. Intrafamilial sexual abuse encompasses abuse by a member of the child's family group which is not limited to sexual intercourse, but rather includes any act designed to stimulate a child sexually or to use a child for sexual stimulation.

Green (1996) suggested that extrafamilial child sexual abuse refers to "a wide range of sexual abuse occurring outside the family. These include single-episode molestation by an adult stranger, single or multiple molestations by an adult acquaintance, sexual victimization in groups (schools, day care centers, clubs, and youth

organizations), and involvement in pornographic sex rings" (p. 74). Green noted that intrafamilial sexual abuse cases are typically reported to and investigated by Child Protective Services agencies, and that these cases may ultimately be referred to the family or juvenile court for a determination of abuse or neglect. In contrast, extrafamilial child sexual abuse is usually reported to the police, and these cases are tried in criminal courts.

Description of a Normative Incestuous Relationship

Brunngraber (1986) and Green (1996) have each provided descriptions of the typical pattern that characterizes incestuous families. Brunngraber suggested that "The daughter involved in paternal incest is usually prepubescent, approximately 11 years-old at the onset of the incest, and is typically the oldest or the only daughter" (Brunngraber, 1986, p. 17). The father generally initiates the sexual contact with his daughter through the use of threats, bribes, rewards, intimidation, misrepresentation of moral standards, or exploitation of his daughter's need to trust a father figure and her desire for affection (Burgess & Holmstrom, 1975; Herman, 1981). The father rarely needs to use physical force. The father has great power by virtue of his parental status, and the child simply complies.

The nature of the sexual contact between father and daughter is progressive. It typically begins with fondling prior to the onset of the daughter's puberty, progresses to oral genital contact, and culminates in genital intercourse after the daughter reaches puberty (Herman & Hirschman, 1977). Incestuous relationships are generally protracted in nature, typically lasting from 1 to 3 years or more (Tormes, 1968). The incestuous sexual relationship generally ends only when the victim discloses it, or when the victim

leaves the home, or when the victim becomes pregnant (De Francis, 1969; Herman & Hirschman, 1981). The frequency of sexual contact during the period of the incestuous relationship is highly variable. Sexual encounters may be sporadic and rare, or regular and frequent. It is not unusual for sexual encounters to occur on a weekly basis or even more than once per week (Courtois, 1979).

Green (1996) discussed the psychodynamics and psychopathology of the incestuous family. Typically the family structure is rigid and patriarchal. Often the father maintains his dominant position in the family through threats, intimidation, coercion, and even violence (Weinberg, 1955). Also, the father is often a substance abuser, and incidents of incestuous sexual contact frequently occur when the father has been using alcohol or some other drug (Cavallin, 1966). Aarens, Camern, and Roizen (1978) estimated that 30% to 40% of all cases of child sexual abuse involve alcohol use. Incestuous families are characterized by a closed family system. Outsiders are often viewed with suspicion, and they are not often invited into the home. Lacking friendship and social support networks, the mothers in incestuous families tend to be overly dependent on their domineering husbands (Meiselman, 1978). Often the mothers are themselves children of substance abusers, and they are far more likely than women in general to have a history of being abused sexually themselves (Green, 1996). Lustig, Dresser, and Spelman (1966) suggested that these codependent women are frequently unavailable to their husbands either sexually or emotionally, and that this unavailability may contribute to the husband's incestuous behavior. However, before we rush to blame one of the ostensible victims in the incestuous family, it should also be noted that the

fathers in incestuous relationships are sometimes pedophiles who are sexually aroused more by their children than by their wives (Groth, 1982).

Green (1996) reported that the roles of the members of incestuous families are frequently confused. The mother may delegate homemaking responsibilities to the victimized daughter. The mother is not very nurturing to her daughter, and the father tends to assume this role, although he does so in the context of the incestuous sexual relationship. Sgroi et al. (1982) suggested that the physical space in the family home often reflects the lack of clear role boundaries among the family members. There may not be sufficient space in the home to afford privacy to each family member. Family members may display inappropriate lack of modesty which occasionally extends to inappropriate nudity around the home.

As in the codependent relationships which characterize substance abusing families, the defense of denial is a hallmark of the incestuous family. The child tends to deny the reality of the situation because she desperately wants to believe that her father is not abusing her. Instead, she may interpret the events as confirming that she is her father's "favorite." The mother tends to deny the reality of the situation because she is dependent on the father and because she fears that recognizing the existence of the incestuous relationship would destroy the family. The father denies the reality of the situation because he is loathe to confront his own pathology.

Prevalence of Child Sexual Abuse and Incest

Estimates of the number of children who are sexually abused each year range from approximately 140,000 per year (U.S. Department of Health and Human Services,

1995) to approximately 200,000 (Finkelhor & Hotaling, 1984) to over 400,000 (Daro & McCurdy, 1992). The latter figure was derived from a study commissioned by the National Committee for Prevention of Child Abuse and carried out in 1991. The investigators surveyed state child protective services agencies, and they determined that 2,694,000 reports of child abuse and neglect were recorded nationally in that year. Fifteen percent of these reports (404,100) were concerned with child sexual abuse. It may be argued on the one hand that this figure is an overestimate because the reports of abuse were registered prior to the conduct of validity investigations by the respective protective service agencies. On the other hand, however, it should be pointed out that these reports were all reports of intrafamilial child abuse whereas the estimate of 200,000 made by Finkelhor and Hotaling included both intrafamilial and extrafamilial abuse. Thus the estimate of Daro and McCurdy may actually be a better reflection of the number of children each year who are victims of incest.

On the other hand, it is possible that all these figures are gross underestimates. Russell (1983) reported that only 2% of intrafamilial sexual abuse cases and only 6% of the extrafamilial sexual abuse cases are reported to CPS or law enforcement agencies. If these estimates are even close to correct, then the number of children who experience incest each year must be much greater.

The denial that characterizes the incestuous family has already been noted, but there are other reasons why incest is frequently unreported. According to Brunngraber (1986), in most cases of prolonged or habitual incestuous contact, the daughters are warned by fathers not to tell anyone about the sexual episodes. Divorce of the parents, punishment of the child, or imprisonment of the father are all suggested to the victim

as possible consequences of her disclosing the secret of sexual victimization" (p. 17).

Furthermore, if the daughter does disclose the incest to her mother or to another family member, it is likely that she will not be believed. Summit (1983) argued that:

> Without professional or self-help group intervention, most parents are not prepared to believe their child in the face of convincing denials from a responsible adult. Since the majority of adults who molest children occupy a kinship or a trusted relationship, the child is put on the defensive for attacking the credibility of the trusted adult, and for creating a crisis of loyalty which defies comfortable resolution. (p. 179)

Thus it would appear to be quite likely that many cases of incest in which the victim does disclose the situation to her mother or another family member nevertheless are not reported officially.

To this point the literature review has focused on father-daughter incest, which has been described as "normative" (To this point the literature review has focused principally on Brunngraber, 1986). According to Green (1996), the great majority of perpetrators of incest are males, and three out of four victims of incest are females. However, it could be argued that if the perpetrator is male and the victim is male, the likelihood that the incest will not be reported may increase, because of the additional societal taboos associated with homosexuality.

Immediate and Long-term Psychosocial Adjustment Difficulties Associated with the Experience of Incest

There was a substantial body of literature concerned with the immediate and long-term effects of childhood sexual abuse. Lusk and Waterman (1986) noted that this literature is highly variable. The great majority of the studies have indicated that childhood sexual abuse has a broad range of negative effects on children, and that many negative effects carry over into adulthood. Mrazek and Mrazek (1981) reviewed the literature and listed 60 different negative effects of childhood sexual abuse.

However, it should be noted in passing that several authors have concluded that the effects of childhood sexual abuse are not wholly negative. For example, Rosenfeld, Nadelson, Krieger, and Backman (1977) concluded that a sexually abusive relationship could provide a child in "an otherwise depriving environment" with a modicum of caring and concern (p. 334). Westermeyer (1978) came to a similar conclusion. Other studies indicating that childhood sexual abuse may have mixed positive and negative effects have been reported by Brunhold (1964), Rosenfeld, Nadelson, and Krieger (1979), and Weiner (1962). Several other studies have concluded that childhood sexual abuse has little or no effect (Bender & Grugett, 1952; Finch, 1967; Powell & Chalkley, 1981; Yorukoglu & Kemph, 1966). However, these studies are relatively rare in comparison to the many studies documenting the negative sequellae of childhood sexual abuse.

Short-term Effects

Among the immediate negative effects of childhood sexual abuse are affective disturbances, psychosomatic disorders, cognitive disturbances, acting-out behaviors, withdrawal, premature sexualization, and self-destructive tendencies.

Affective disturbances. Several studies have indicated that sexually abused children tend to manifest guilt and shame (Boatman, Borkan, & Schetky, 1981; Dixon & Jenkins 1981; MacFarlane & Korbin, 1983; Simari & Baskin, 1982). These studies were based primarily on clinical observation, but the conclusions were sufficiently uniform that one may have a fair degree of confidence that abused children do indeed experience guilt. Children appear to blame themselves for the abuse. This is especially true if they enjoyed aspects of the sexual relationship or if they were otherwise rewarded for their sexual behavior. When children disclose abuse, they may also experience guilt associated with the belief that they may have precipitated the destruction of the family.

Another affective reaction to sexual abuse is anxiety (Adams-Tucker, 1981, 1982; Brassard, Tyler, & Kehle, 1983; Goodwin, 1982; Kelly, 1982; Tufts New England Medical Center, 1984; Yates, 1982). Such anxiety may be manifested in various ways, including: (a) somatic and behavioral symptoms, such as enuresis or tics (Department of Health and Human Services, 1981); (b) phobias and nightmares (Weiss, Rogers, Darwin, & Dutton, 1955); (c) separation anxiety (Brandt & Tiza, 1977); and (d) social anxiety (Brassard et al., 1983). Such anxiety may be quite severe. Adams-Tucker (1981) reported that among 28 sexually abused children seen in an outpatient clinic, anxiety was the primary presenting problem in the majority of cases. A related affective disturbance among sexually abused children is fear (Brassard et al., 1983; Finkelhor, 1987; Goodwin,

1982; Summit, 1983; Tufts New England Medical Center, 1984; Vander Mey & Neff, 1982).

Many sexually abused children experience depression (Blumberg, 1981; Brooks, 1982; Diaz, 1994; Perlmutter, Engel, & Sager, 1982; Simari & Baskin, 1982; Tufts New England Medical Center, 1984; Yates, 1982). Blumberg (1981) concluded that recurring sexual abuse will "almost invariably result in an ongoing depressive state" (p. 349). Depression appears to characterize victims of childhood sexual abuse of all ages, including both preschoolers (Tufts, 1984; Yates, 1982) and adolescents (Diaz, 1994; Heims & Kaufman, 1963).

Finally, abused children tend to experience intense feelings of anger (Browning & Boatman, 1977; Krieger, Rosenfeld, Gordon, & Bennett, 1980; Simari & Baskin, 1982; Steele & Alexander, 1981). In cases of father-daughter incest, the anger is typically directed toward both parents (Steele & Alexander, 1981).

Psychosomatic disorders. Many investigators have reported an increased likelihood of psychosomatic complaints among sexually abused children (Adams-Tucker, 1982; Blumberg, 1981; Boekelheide, 1978; Goodwin, 1982; Gross, 1982; Sgroi, 1982; Yates, 1982). These complaints include stomachaches, headaches, hypochondriasis, encopresis, enuresis, and seizures. In addition, abused children often display changes in appetite (Brassard et al., 1983) and difficulty sleeping (Adams-Tucker, 1982; Brassard et al., 1983; Goodwin, 1982).

Cognitive disturbances. Johnston (1979) reported that sexually abused children frequently have difficulty concentrating on tasks. Shaw and Meier (1983) concluded that sexually abused children tend to have short attention spans. It has also been suggested that sexually abused children may experience difficulties in school because they feel powerless and not in control of possible outcomes (Jiles, 1981). Other investigators have described a "helpless victim" mentality in sexually abused children which keeps them from applying themselves toward achieving goals (Knittle & Tuana, 1980; Summit, 1983).

Acting out behaviors. Aggressive and antisocial behavior is common among sexually abused children (Adams-Tucker, 1981; Bess & Janssen, 1982; De Francis, 1970; Finkelhor, 1987; Tufts New England Medical Center, 1984). Young children who are abused often have temper tantrums (Adams-Tucker, 1981). School-aged children who are sexually abused are at increased risk of truancy and delinquent behaviors (Blumberg, 1978; Vander Mey & Neff, 1982). Sexually abused adolescents are also more likely than non-abused children to abuse alcohol or other drugs (Herman & Hirschman, 1981; Riggs, 1982; Spencer, 1978; Summit, 1983; Vander Mey & Neff, 1982).

Withdrawal. While externalizing pathology is the most common behavioral manifestation of sexual abuse, some abused children display internalizing pathology, typically in the form of withdrawal (Adams-Tucker, 1981; Burgess & Holmstrom, 1975; Diaz, 1994; Jiles, 1981; Riggs, 1982). Such youngsters may stay inside and refuse to leave the house (Burgess & Holmstrom). They may withdraw into fantasy (Riggs, 1982). They may also manifest regressive behaviors, such a thumb-sucking, fear of the dark, or

fear of strangers (Adams-Tucker, 1981; Brassard et al., 1983; Riggs, 1982). Adolescents who are sexually abused may fail to develop age-appropriate interpersonal relationships (Diaz, 1994).

Premature sexualization. Numerous authors have suggested that sexual abuse leads to premature sexualized behaviors in children (Brandt & Tiza, 1977; Brassard et al., 1983; Finch, 1973; Freud, 1981; Krieger et al., 1980; Riggs, 1982; Sgroi, 1982; Tufts New England Medical Center, 1984; U.S. Department of Health and Human Services, 1981; Yates, 1982). The Tufts New England Medical Center study (1984) indicated that 36% of the 113 sexually abused children in the study had engaged in premature sexual behavior other than the initial sexual abuse within 1 year following the disclosure of the abuse. Other manifestations of premature sexualization include the manifestation of atypical knowledge of sexual acts and preoccupation with sexual matters (Brassard et al., 1983; Riggs, 1982). Some sexually abused children manifest confusion regarding sexuality and their sexual orientations (Boatman et al., 1981; Brooks, 1982; Jiles, 1981). Premature sexualization has been explained as the result of the lack of the normal inhibition of sexual impulses (U.S. Department of Health and Human Services, 1981). It has also been characterized as a means through which the victim can "work through" the abuse (Finch, 1973). Lusk and Waterman (1986) reported that adolescent and even latency-aged victims of sexual abuse often perpetrate sexual abuse on other children in an effort "to master their own trauma by victimizing younger children" (p. 106). Diaz (1994) reported that sexually abused adolescent girls reported more sexual avoidance than non-abused age peers. However, her sexually abused sample also scored higher than the non-abused sample on a measure of sexual risk-taking.

Self-destructive behavior. It has been observed that sexually abused children frequently self-mutilate (Adams-Tucker, 1981; Knittle & Tuana, 1980; Simpson & Porter, 1981; Summit, 1983). Knittle and Tuana (1980) suggested that self-mutilation derives from anger turned inward. Thus self-mutilation can be thought of as having the same etiology as the more commonly encountered depression that characterizes sexually abused children.

It has also been observed that sexually abused children tend to display elevated scores on measures of suicidal ideation and increased likelihood of making suicide attempts (Bess and Janssen, 1982; Diaz, 1994; Perlmutter et al., 1982).

Long-term Effects of Childhood Sexual Abuse

The long-term effects of childhood sexual abuse include both continued manifestations of short-term effects noted above as well as psychosocial adjustment difficulties which manifest themselves later in the lifespan. The continued manifestations of short-term effects will be considered first.

The guilt experienced by sexually abused children at the time of the abuse may continue and even increase as time passes. Rosenfeld et al. (1979) suggested that the guilt experienced by children often intensifies over time as the child gains a clearer understanding of cultural norms and taboos. Manifestations of anxiety and fear, including phobias and nightmares, may persist into adulthood (Weiss et al., 1955). It has been suggested that the anger experienced in childhood and the depression that may develop as this anger is turned inward often persist into adulthood (Evans & Sullivan, 1995; Simari & Baskin, 1982).

The "helpless victim" orientation that has been attributed to sexually abused children frequently persists into adulthood. Adults who were sexually abused as children continue to lack interpersonal relationship skills, particularly parenting skills (Cole et al., 1992). In addition, individuals who are abused sexually during childhood are often revictimized as adults (Evans & Sullivan, 1995). In other instances, however, individuals who were sexually abused as children assume the role of perpetrator as adults (Blumberg, 1978; Brooks, 1982; Cohen, 1981; Freud, 1981; Green, 1991; Steele & Alexander, 1981). Groth and Birnbaum (1978) observed that adult perpetrators of child sexual abuse frequently report being abused themselves as children, typically when they were about the same age as their own victims.

The premature sexualization observed in many children who were victims of sexual abuse appears to be reflected in a variety of sexual adjustment difficulties in adulthood. A history of childhood sexual abuse has been related to promiscuity in adulthood (Brooks, 1982; Brunold, 1964; Finch, 1967; Herman & Hirschman, 1981; Vander Mey & Neff, 1982). It has been argued that childhood sexual abuse leads to prostitution (Blumberg, 1978; Spencer, 1978; Vander Mey & Neff, 1982). Childhood sexual abuse has also been shown to be related to a variety of sexual dysfunctions in adulthood, including sexual inhibition and orgasmic dysfunction (Bess & Janssen, 1982; Blumberg, 1981; Brooks, 1982; Freud, 1981; Sgroi, 1982; Steele & Alexander, 1981; U.S. Department of Health and Human Services, 1981; Vander Mey & Neff, 1982).

Self-destructive behaviors which were sometimes observed in abused children tend to persist into adulthood. The incidence of substance abuse and addiction in adulthood was far greater among individuals who were sexually abused as children than

among individuals who were not abused (Evans & Sullivan, 1995). Suicidal ideation and suicide attempts were also more likely to be observed among adults who were abused as children than among those who were not (Davidson et al., 1996; Herman & Hirschman, 1981; Perlmutter et al., 1982).

In addition to the ongoing manifestations of the effects of sexual abuse which first appeared during childhood, adult victims of childhood sexual abuse have been shown to manifest increased likelihood of being diagnosed with several serious psychiatric disorders, including bulimia and related eating disorders (Cole & Putnam, 1992), borderline personality disorder (Harney, 1992; Zanarini, 1997), alexithymia (Zeitlin, McNally, & Cassiday, 1993), and dissociative identity disorder, formerly referred to as multiple personality disorder (American Psychiatric Association, 1987; Kaplan, 1996). The paragraphs that follow consider each of these diagnoses in turn.

Bulimia. Briere (1992) noted that clinicians who treat adult survivors of childhood sexual abuse report that many of their clients have eating disorders, particularly bulimia. Conversely, clinicians who work with individuals with eating disorders have reported that these individuals frequently report a history of childhood sexual abuse (Kearney-Cooke, 1988; Zerbe, 1992). Several researchers have reported positive correlations between childhood sexual abuse and bulimia in both clinical and non-clinical samples (Bulik, Sullivan, & Rorty, 1989; Calam & Slade, 1989; Lacey, 1990; Smolak, Levine, & Sullins, 1990). On the other hand, Korte, Horton, and Graybill (1998) reported "minimal overlap" between individuals in a large non-clinical sample who reported a history of childhood sexual abuse and individuals who reported bulimic behaviors (p. 53).

Several explanations have been offered for the reported relationship between childhood sexual abuse and eating-disordered behaviors. Several investigators have suggested that the relationship is mediated by low self-esteem, which may result from childhood sexual abuse and contribute to eating disorder pathology (Miller, McCluskey-Fawcett, & Irving, 1993; Waller, 1992). Other investigators have argued that the relationship may be mediated by dissociation (Briere, 1992; Herzog, Staley, Carmody, Robbins, & van der Kolk, 1993; Root & Fallon, 1989). According to this line of reasoning, sexually abused children employ the defense mechanism of dissociation to protect themselves from the trauma of the abuse. The use of this defense mechanism continues into adulthood and generalizes to other contexts. Dissociation may activate bulimic behavior, since it results in the suspension of the normal ego controls which inhibit binge eating. Neither of these explanations has yet received substantial empirical support, although both explanations are the subjects of ongoing investigations (Saligman, personal communication, September, 1998).

Borderline Personality Disorder. A number of studies have indicated that childhood abuse, both physical and sexual abuse, were commonly reported by patients diagnosed as having borderline personality disorder (BPD) (Herman, Perry, & van der Kolk, 1989; Links, Steiner, & Offord, 1988; Orgata, Silk, & Goodrich, 1990; Salzman, Salzman, & Wolfson, 1993; Shearer, Peters, & Quaytman, 1993). In these studies, the proportion of adult borderline patients who reported that they had been abused physically as children ranged from 10% to 71%, and the proportion who reported that they had been abused sexually ranged from 16% to 71%. The proportion of borderline patients who

reported having had an incestuous relationship with a full-time caretaker was as high as 33% (Zanarini, Dubo, Lewis, & Williams, 1997).

Although physical abuse was as common as sexual abuse in the history of borderline patients, physical abuse significantly discriminated borderline from nonborderline patient groups in only one study (Links et al., 1988). In contrast, all the studies cited in the preceeding paragraph indicated that a significantly higher percentage of borderline patients reported a history of childhood sexual abuse than the proportion of patients with other diagnoses who reported such abuse. These findings have been interpreted as indicating that childhood sexual abuse is "the main etiological factor in the development of BPD" (Zanarini et al., 1997). It has also been proposed that some patients who meet the diagnostic criteria for BPD may actually be characterized more accurately as having a chronic form of post traumatic stress disorder (Herman, 1992; Herman & van der Kolk, 1987).

On the other hand, a note of caution is warranted when drawing conclusions regarding the possible causal relationship between childhood sexual abuse and BPD, since children who are sexually abused frequently suffer as well from one or more other forms of abuse. Zanarini and her associates (1997) found that groups of borderline patients who had a history of childhood sexual abuse ($n = 46$) and no history of sexual abuse ($n = 32$) differed significantly with respect to history of emotional abuse, physical abuse, and emotional withdrawal.

Alexithymia. Alexithymia is a multidimensional construct that is characterized by difficulty in identifying and describing feelings, difficulty in distinguishing between feelings and bodily sensations, an impoverished fantasy life, as well as speech and

thought that are concrete and tied closely to external events (Sifneos, 1973, 1975). Krystal (1982) suggested that alexithymia develops in response to extreme trauma. He opined that alexithymia serves much the same function as the defense mechanism of dissociation, i.e., to protect an individual from experiencing painful affect.

Lusk and Waterman (1986) reported that alexithymia is characteristic of adult male and female victims of childhood sexual abuse. Scher and Twaite (1999) studied a sample of 136 adults in treatment for substance abuse. They measured alexithymia using the self-report Toronto Alexithymia Scale (TAS). They also obtained self-reports of physical and sexual abuse experienced during childhood and as an adult, as well as data relevant to the nature of the sexual abuse experienced, including number of instances of abuse, age of onset of abuse, duration of abuse, and the nature of the abuse (dichotomized into sexual abuse involving oral, vaginal, or anal penetration versus abuse not involving penetration). Scher and Twaite (1999) found that substance abusers with a history of childhood sexual abuse had significantly higher scores on the TAS than did substance abusers with no history of sexual abuse. They also observed that the severity of alexithymic symptoms was related positively to the duration of the period over which the abuse occurred, but not to the number of instances of abuse. Children who were sexually abused after the age of 12 had significantly higher scores on the TAS than did children who were abused sexually before the age of 12. Children who experienced sexual abuse involving penetration had significantly higher TAS scores than did children who reported experiencing childhood sexual abuse not involving penetration.

Dissociative identity disorder. Dissociative identity disorder (DID) is the term used by the DSM-IV to refer to the condition formerly referred to as multiple personality

disorder (MPD) (American Psychiatric Association, 1994). Dissociative identity disorder is the most chronic and most extreme form of dissociation (Green, 1996; Kluft, 1985; Kluft, Steinberg & Spitzer, 1988; Steinberg, 1995). According to Steinberg, dissociative identity disorder "is characterized by separate identities existing within one individual, which may control his or her behavior or attitudes, leading to internal struggle and confusion over the nature of personal identity" (p. 283). In many cases, the patient will remain amnestic for periods when alternate personalities predominate. However, in other cases, patients may be able to have internal conversations or other interactions between two or more of the alter personalities.

According to the DSM-IV (American Psychiatric Association, 1994), there are four criteria for the diagnosis of DID: (a) the presence of two or more distinct identities or personality states, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self; (b) at least two of these identities or personality states recurrently take control of the person's behavior; (c) the inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness; and (d) the disturbance is not attributable to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or a general medical condition (e.g., complex partial seizures).

The DID diagnosis in adults has been defined as associated positively with a history of childhood sexual abuse (Kluft, 1985; Putnam, 1985; Stern, 1984; Wilbur, 1984). Goodwin et al. (1989) specifically suggested that MPD occurs disproportionately often within the population of adult incest survivors.

In conclusion, there was ample literature indicating that childhood sexual abuse is associated with a wide variety of serious psychosocial adjustment difficulties. Many of these difficulties emerge with the onset of the abuse. The problems may increase as the abuse continues. When the abuse is intrafamilial, the difficulties experienced by the child may be exacerbated when he or she gains increased understanding of the prevailing social proscriptions against this behavior. Difficulties that emerge in childhood may persist into adulthood. In addition, in populations of adults, several specific psychiatric diagnoses have been found to be associated positively with a history of having been sexually abused as a child.

Theoretical Models of the Dynamics of Child Sexual Abuse and Incest

The impact of childhood sexual abuse has been explained in terms of post-traumatic stress disorder (PTSD) (American Psychiatric Association, 1994; Diaz, 1994). This model applies equally well to abuse experienced as a child or as an adult. Finkelhor and Browne (1985) have presented an alternative to the PTSD model which may offer a more complete explanation of the symptoms associated with childhood sexual abuse specifically. Cole and Putnam (1992) have attempted to describe the dynamics of intrafamilial childhood sexual abuse specifically. This section of the review considers each of these conceptualizations.

According to the DSM-IV, the essential feature of post-traumatic stress disorder (PTSD) is "the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity" (p.

424). According to the DSM-IV, an individual's response to the event must involve intense fear, helplessness, or horror. In the case of a child, it must involve disorganized or agitated behavior. According to the DSM-IV a sexual assault is one of the traumatic events that may lead to PTSD in adults. However, according to the DSM-IV, the criteria for sexually traumatic events include "developmentally inappropriate sexual experiences without threatened or actual violence or injury" (p. 424).

The symptoms of PTSD which were mentioned in the DSM-IV included: (a) the consistent re-experiencing of the trauma, either through recurrent intrusive recollections, or dreams, or sudden uncontrollable feelings; (b) avoidance or general numbing of responsiveness to stimuli associated with the trauma, which includes reduced involvement in the external world; and (c) persistent symptoms of increased arousal, such as hyperalertness, sleep disturbances, survival guilt, difficulties with memory or concentration, and avoidance of activities.

Diaz (1994) concluded that "The PTSD concept, though not clearly formulated theoretically, is a notable movement forward in providing clear descriptors for children and adult victims of abuse experiences. As such, it puts them in the company of others who have been through devastating experiences" (p. 21). However, Finkelhor (1988) pointed out that the diagnosis of PTSD may not be clear-cut in cases of sexual abuse that do not occur with actual or threatened physical injury. The symptoms of PTSD included in the DSM-IV do not include several of the important characteristics of victims of sexual abuse. These include fear, depression, self-blame, and sexual dysfunction. The PTSD model appears to focus on extremes of explosive affect or extremely constricted affect. However, the PTSD model does not address the cognitive consequences of child sexual

abuse, which include low self-esteem and sexual misinformation. Furthermore, the PTSD syndrome does not encompass some of the most frequently observed correlates of childhood sexual abuse, including suicidality, substance abuse, and the tendency toward revictimization.

Finkelhor and Browne (1985) presented the Traumagenic Dynamic Model to provide a more complete explanation of the symptoms associated with childhood sexual abuse. According to Finkelhor and Browne, (1985) sexual abuse leads directly to four "traumagenic dynamics": (a) traumatic sexualization, (b) betrayal, (c) stigmatization, and (d) powerlessness. Finkelhor and Browne (1985) suggested that a traumagenic dynamic alters a child's cognitive and emotional orientation to the world, causing trauma by distorting the child's self-concept, world view, or affective capacities. Finkelhor and Browne described these distortions as underlying the psychological and behavioral problems which characterize sexually abused children and adults with histories of sexual abuse.

Traumatic sexualization refers to the manner in which a child's sexuality is shaped by sexual abuse in developmentally inappropriate and interpersonally dysfunctional ways. For example, sexually abused children are often rewarded for their sexual behavior, so they may learn to use sexuality to manipulate others. Certain parts of their bodies may become fetishized. These children are confused about normal sexuality and morality, and they may be sexually dysfunctional as adults.

Sexually abused children experience betrayal when they realize that someone upon whom they were dependent has caused them harm. This realization may occur at the time of the first incident of abuse, or it may occur later in the child's life. The child

may also feel betrayed when he or she reports the abuse to non-offending family members, because others in the family are often unwilling or unable to believe that the abuse has occurred.

Children who are abused are likely to be stigmatized by the negative moral and societal judgments associated with sexual behavior. They are likely to feel that they are evil, worthless, ashamed, and guilty. Rogers and Terry (1984) argued that male children are likely to feel particularly stigmatized because of the homosexual connotation of the abuse.

The dynamic of powerlessness refers to both the repeated dismissal of the child's wishes and sense of efficacy, and to the possible threat of injury. The repeated invasion of one's body space against one's wishes makes one feel powerlessness, regardless of whether this takes place as a result of force or deceit. When the abuse was accompanied by violence or coercion, the feeling of powerlessness was intensified. Feelings of powerlessness are also exacerbated when children unsuccessfully resist their abusers.

Cole and Putnam (1992) presented a model for the explanation of the effects of incest in particular. They argued that incest is particularly injurious to the development of a sense of security and trust in relationships. This is because the victim must deal not only with trauma and guilt but also with the reality of being hurt and betrayed by an extremely important and formerly trusted caretaker. This will tend to have a long-term negative impact on the ability of the victim to have satisfying relationships with feelings of being loved and protected. This dynamic would lead one to suspect that individuals who have been victims of childhood sexual abuse might derive great benefit from the experience of a warm, trusting, reparative therapeutic relationship.

Repressed Memories of Childhood Trauma

An intense debate has been raging within the field of psychology regarding the veracity of memories of childhood sexual abuse which emerge during the process of psychotherapy (Loftus, 1993, 1994; Olio & Cornell, 1994; Ware, 1995). It has been argued that patients may develop "false memories" of sexual abuse, because their therapists may have an unconscious need to find sexual abuse and therefore directly or indirectly suggest to the patient that such abuse has occurred (Loftus, 1993; Nash, 1994; Sarbin, 1997).

Prozan (1999) observed that there are three kinds of patients who present for psychoanalytic psychotherapy for problems associated with a history of childhood sexual abuse: (a) those who have a complete memory of the sexual abuse and the associated negative feelings; (b) those who have memory of the abuse, but who have repressed the negative affect associated with the abuse and dissociated the most painful details; and (c) those who have no memory of the abuse because they have totally repressed the trauma. Prozan (1999) suggested that with patients in the first group, the work of therapy consists of "understanding the long-term effects of the abuse and how it may be related to the patient's current symptoms and relationship problems" (p. 118). Prozan argued that for patients in this group, issues of therapist suggestion and the accuracy of the recollection of childhood sexual abuse are not relevant. Among patients in the second group, who remember the abuse but have repressed the associated affect, the work in therapy is directed toward uncovering the repressed affect and the fuller picture of what was done to the child as well as the long-term effects. In these cases, Prozan suggested that therapist

suggestion is not a significant problem, although "a certain amount of speculation may be part of the process" (p.119).

For patients in the third group, those who have repressed the abuse entirely, Prozan (1999) suggested that "clues emerge during therapy, and memory is reconstructed" (p. 118). She pointed out that these patients may manifest great resistance to overcoming repression, because remembering the abuse brings forth shame, anger, fear, and guilt. Prozan argued that with such patients it is important for the therapist to be aware of the possibility that sexual abuse has occurred, or else an important component of the patient's history may be ignored. However, Prozan also recognized that questioning and making interpretations in the face of the patient's denial, resistance, or repression "is risky with a suggestible patient" (p. 122). She stated that, "Therapists who expect to find sexual abuse in their patients' childhood may make a critical error and bias their investigation" (p. 116). Prozan referred to the Holly Ramona case, in which a father successfully sued two therapists, accusing them of planting false memories of sexual abuse in his daughter's mind.

Flathman (1999) cited a number of reasons why memories of childhood sexual abuse which emerge during the process of psychotherapy may be inaccurate. He noted that memory for autobiographical life events generally does not stretch back before the age of 2 to 3 years, and he suggested that the prevalence of this phenomenon of "infantile amnesia" warrants great caution with respect to recollections of any events which may have occurred during the first 2 to 3 years of life. Furthermore, Flathman pointed out that trauma "interferes with the ability to process an event in ways that allow for accurate storage, retention or recall" (p. 5). Thus, one's memories of childhood sexual abuse

would be expected to be even less reliable than memories of one's early childhood in general. Finally, Flathman cited several studies indicating that all memory is malleable. Loftus (1993) provided several anecdotal accounts of instances in which an individual's memories of an actual event were modified or an individual had a recollection of an event which in fact never occurred. Garry and Loftus (1994) showed that an individual's recollections of an actual event can be modified by misinformation regarding the event received subsequent to that event. Moreover, once influenced by misinformation, subjects are not easily dissuaded that their factually inaccurate "memories" are not indeed what they remember. Loftus (1992) referred to this phenomenon as "turning a lie into the memory's truth" (p. 122).

An American Psychological Association Working Group suggested that practitioners should maintain an open mind with respect to patients who claim to have delayed memories of childhood sexual abuse (Alpert et. al, 1995). The group suggested that practitioners keep in mind the following possibilities with respect to such claims: (a) the retrieved material is a reasonably accurate memory of real events; (b) the material is a distorted memory of real events, with the distortion due to developmental factors or source contamination; (c) the material is a confabulation emerging from underlying psychopathology or difficulties with reality testing; and (d) the material is a pseudomemory emerging from exposure to suggestions.

Lindsay and Briere (1997) have argued that the idea that recovered memories are either always illusory or always veridical is a dangerous oversimplification. They recommended that clinicians keep the four possibilities enumerated by the APA Working Group firmly in mind to keep them from adopting a dichotomous conceptualization of

delayed memories. Flathman (1999) concluded that "there may be gradations of historical truth in any reported memory" (p. 17). He also argued that the treatment of child abuse survivors is not primarily about recovering memories, but rather about establishing a strong therapeutic relationship of trust, a trust that has been violated by conditions of abuse in the past.

Therapist Attributions of Blame for Incest

Josephson and Fong-Beyette (1987) studied female victims of incest who sought counseling. They were interested in identifying the factors associated with disclosure of the incest to their therapists. They found that women tended to disclose when they believed that disclosing would alleviate their distress. This belief was sometimes based on reports in the media indicating that disclosure would be helpful and sometimes based on advice to this effect received from family or friends. In addition, the likelihood of disclosure was related to certain types of behavior on the part of the therapist. Specifically, victims were more likely to disclose when their therapists were comfortable with the subject and encouraged discussion of the incest. Victims were also more likely to disclose when they felt comfortable with the therapist. Comfort with the therapist was associated with therapist warmth and acceptance, whereas discomfort was associated with the tendency of the therapist to assign some or all of the blame for the incest to the victim. Thus, it is clearly important to understand the factors associated with therapist attributions of blame in cases of incest. As discussed in the first chapter, therapists' attributions of blame for incest would be expected to be related to their training and experience. It seems axiomatic that therapists with more training and experience would

be less likely to attribute blame to the victim than less experienced practitioners. The findings reported by Josephson and Fong-Beyette (1987) provided support for this position. This study also indicated an effect due to therapist gender, such that: (a) female incest victims felt more positively toward female therapists than toward male therapists, and (b) female incest victims were more likely to disclose their history of abuse to female therapists than to male therapists.

In addition, two therapist personality factors appear to be crucial to the question of attribution of blame and to the willingness of the client to be open about childhood sexual abuse experiences. These factors are empathy (Davis, 1996; Josephson & Fong-Beyette, 1987) and locus of control (Doherty & Ryder, 1979; Rotter, 1990; Rotter et al., 1962). The importance of empathy on the part of the therapist seems fairly obvious. An empathic therapist would be able to place herself in the position of the victim and to understand the disparity of power between victim and perpetrator. This stance would clearly be expected to manifest itself in the attribution of blame for incest to the perpetrator of the victim rather than the victim, as well as in sympathetic and reassuring responses which would be expected to increase the client's degree of comfort in revealing sensitive information regarding the incest.

The importance of the therapist's locus of control is less obvious and perhaps more indirect, yet perhaps even more profound. First, the therapist with a strong internal locus of control would logically be less threatened by information regarding incest than a therapist with an external locus of control. This would be expected to be reflected in greater efforts to elicit self-disclosure from the client, a factor which has shown to be related directly to disclosure of aspects of the incest (Frenken & Van Stolk, 1990).

Second, the therapist with a strong internal locus of control would be expected to convey a sense of self-confidence and the idea the therapeutic process can actually alleviate the discomfort being experienced by the victim. Confidence in the potential positive outcomes of treatment would be expected to engage the client in the therapeutic process, including the need to discuss aspects of the incest experience.

Third, it was important to recognize that one of the most devastating aspects of the experience of childhood sexual abuse is the sense of helplessness associated with victimization. Given the power differential inherent in the sexual abuse of children, resistance is ineffective. This is terrifying in the short-term, and in the long-term it can engender learned helplessness, i.e., the lack of proactive behavior based on the belief that one is incapable of altering outcomes (Lefcourt, 1990, 1991). Given a client with such a belief system, a therapist with a strong internal locus of control would be expected to provide an important role model for positive goal-directed behavior.

A final issue to be addressed was the question of the effect on therapist attribution of blame for incest on (a) therapist gender, and (b) the gender match of therapist and client. Eisenberg and Lennon (1983) noted that the impression long held by psychologists and the population at large is that females are more empathic than men. This might lead us to hypothesize that female therapists are less likely than male therapists to attribute blame for incest to the victim. However, Davis (1996) has suggested that the question of gender-related differences in empathy is a complex problem requiring a careful analysis of the research findings. Based upon a review of the literature in this area, Davis concluded that:

> Women reliably describe themselves on personality questionnaires as more likely to react affectively to the experiences of other people, but measurements taken in specific situations reveal them to be generally no more reactive than men, either physiologically or in terms of their subjective emotional experience. (pp. 60-61)

Davis (1996) explained this apparent contradiction in terms of sex-role stereotypes. He argued that it is more acceptable in our society for women to be empathic than it is for men to be empathic. Accordingly, when a woman completes a self-report measure of empathy, she can feel comfortable endorsing responses indicating high levels of empathy. A male respondent may feel somewhat less comfortable responding in this way. Therefore, on self-report measures, women come out looking more empathic. However, in laboratory studies employing physiological or observational measures of responsiveness, the social desirability factor is eliminated. In these situations, no gender-related differences in responsiveness emerge.

Thus Davis concluded that there is no actual gender difference in empathy, but only an artifactual difference due to response bias driven by sex role stereotypes. Accordingly, in a simulation study such as that proposed here one would not necessarily expect to find significant differences due to therapist gender in attributions of blame toward the victim. However, one might well expect to find significant interactions between the gender of the therapist and the gender of the victim, such that therapist attributions of blame toward the victim might be lower in same sex therapist/client dyads than in opposite sex therapist/client dyads.

Summary and Directions for Research

The literature discussed in the first two chapters of this study made it clear that child sexual abuse is quite common in our society, and that victims of child sexual abuse often experience serious immediate and long-term psychosocial adjustment problems. We have also seen that victims of child sexual abuse who seek psychotherapy tend to be dissatisfied with their treatment, a phenomenon which may be related to the tendency of therapists to attribute some or all of the blame for the sexual abuse to the victim.

A review of the literature on attribution of blame with respect to victims of incest yielded no direct empirical report of the extent to which therapists actually attribute blame to incest victims, and no investigation of therapist variables which may be associated with the tendency to blame the victim. However, anecdotal data reported by Jacobson and Fong-Beyette (1987) suggested that incest victims in therapy sometimes do perceive their therapists as attributing blame to them. It is therefore necessary to carry out research to determine the extent to which therapists do attribute blame to incest victims, as well as research aimed at identifying therapist characteristics predicting such attributions.

The literature suggested that therapist empathy and therapist locus of control may be important factors influencing the relationship between the therapist and a victim of childhood sexual abuse. The literature also clearly indicated that a perception on the part of a victim that the therapist may be attributing part or all of the blame for the abuse to the victim is a major source of dissatisfaction which frequently results in the termination of treatment. However, a review of the literature yielded no empirical studies on the relationship between attribution of blame and therapist empathy, and no studies of the

relationship between attribution of blame and therapist locus of control. Accordingly, the proposed study described here was designed to assess these relationships, as well as the relationship between attribution of blame and selected aspects of the therapist's background and training.

Chapter III

Hypotheses and Methods

The study presented here involved a survey questionnaire to determine therapists' attributions of blame for incest. The survey used vignettes and semantic differential rating scales to ascertain the relative blame that therapists ascribe to a victim of sexual abuse, and to the father and mother of that victim. Also ascertained by the survey questionnaire were the responding therapists' genders, aspects of their training and experience, as well as therapists' measured levels of empathy and locus of control. In this chapter, the hypotheses that were tested are stated, and the methods employed in the study are described, including the participants, the procedures, the survey instrument, and the methods of data analysis that were employed.

Hypotheses to Be Tested

Based on the foregoing introduction and review of the relevant literature, the following research hypotheses were tested in the proposed study:

H1: There will be no significant main effect attributable to therapist gender on the therapist's tendency to attribute blame to the victim of incest. However, there will be a significant interaction between a therapist's gender and the gender of the victim, such that male therapists will be more likely than female therapists to attribute blame to a female victim than to a male victim, whereas female therapists will be more likely to attribute blame to a male victim than to a female victim. This hypothesis was based on the finding reported by Josephson and Fong-Beyette (1987) that female victims of father-

daughter incest felt more comfortable disclosing their incest experiences to female counselors than to male counselors.

H2: The tendency to attribute blame to the victim of incest will be related significantly to the training and experience of the therapist. Specifically, the tendency to attribute blame to the victim will be related negatively to the therapist's: (a) years of experience, (b) specific experience treating victims of childhood sexual abuse, (c) exposure to preservice education on incest, (d) level of education, and (e) exposure to inservice education on incest. These effects will pertain regardless of the gender of the therapist or the gender of the victim

H3: There will be a significant relationship between measured therapist personality characteristics and the therapist's attributions of blame to the victim of incest. Specifically, the tendency to attribute blame to the victim will be related significantly to the therapist's empathy and to the therapist's locus of control. Therapists who have greater empathy will be less likely than those who are less empathic to attribute blame to a victim. Therapists who have a relatively internal locus of control will be less likely than those with a relatively external locus of control to attribute blame to the victim. These effects will pertain regardless of the gender of the therapist or the victim.

Participants

The participants in the study included 202 therapists representing various professional disciplines and levels of educational attainment. The therapists included social workers, psychologists, psychiatrists, marriage and family therapists, and school guidance counselors. These groups were chosen because they represent professionals

who are likely to come into contact with victims of sexual abuse. The participants included individuals who work in institutional settings as well as individuals who are involved primarily in private practice. The therapists were not limited to individuals who have actually worked with victims of incest, nor were such individuals excluded from the study.

The use of therapists representing various disciplines and work venues was designed to maximize the variability of the sample with respect to the predictor variables of empathy, gender, years of clinical experience, extensiveness of experience working with victims of incest, and self-reported exposure to preservice and inservice educational experiences concerned with the treatment of incest survivors. The investigator assumed that greater variability within the sample with respect to these factors would increase the chance that significant findings would be obtained.

A minimum sample size of 200 was established on the basis of a statistical power calculation. With 200 therapists, the vignettes can be altered, so that at least 100 therapists will read a vignette with the incest victim was described as a female, and at least 100 other therapists will read the same vignette with the victim described as a male. Under these circumstances, an independent sample *t* test comparing the attributions of blame assigned to male and female victims would have a power of .80, assuming a medium effect size of .40 standard deviations and a two-tailed significance test at the .05 level of significance (Cohen, 1988, p. 37). In this context, effect size refers to the magnitude of the actual difference between the means of the populations being compared.

Furthermore, within each of the groups of at least 100 therapists who will rate a either a female or a male victim of incest, a Pearson correlation assessing the relationship between measured therapist empathy and the tendency to attribute blame to the victim would have a power of .92, assuming a medium effect size ($r > .30$) and a two-tailed hypothesis test carried out at the .05 level of significance (Cohen, 1988, p. 86). In this context, effect size referred to the actual magnitude of the correlation within the population that will be represented in the sample.

Procedures

A convenience sample was employed. The investigator solicited the participation of professional colleagues and employed a mushroom sampling procedure in which each successive respondent is asked to recommend other potential respondents. Because of the nature of the sampling procedure, it was anticipated that the majority of the respondents would come from the Northeast metropolitan area.

The investigator contacted potential respondents by letter, telephone, or in person. She explained that, for the purpose of completing her doctoral dissertation, she was doing a study of therapists' perceptions of family members involved in a variety of different family situations. The investigator indicated that participation in the study would require approximately 30 minutes of the respondents' time, and that responses would be completely anonymous.

A cover letter preceding the survey questionnaire reiterated this information regarding the requirements of participation. This cover letter instructed each potential participant explicitly not to write his or her name or any other identifying data on

the survey questionnaire, so as to guarantee anonymity. The cover letter contained a request that those who decided to participate to sign an informed consent form and to return it separately from the survey itself, so as to maintain anonymity of responses. A copy of the cover letter is presented in Appendix A.

Whether a given respondent received a survey in which the victim of incest is described as male or a survey in which the victim is described as female was determined randomly.

Approximately 2 weeks following the delivery of the survey questionnaire to each respondent, a follow-up postcard was mailed. This postcard thanked the respondent if he or she has already returned the survey, and reminded potential respondents who had not yet returned their surveys of the need to return them as quickly as possible. Since the surveys were administered anonymously, all potential respondents received the follow-up postcard, and it was worded in such a way as to be relevant to those who had already responded as well as to those who had not yet responded.

Since the semantic differential technique is well-established (Kerlinger, 1972; Osgood, Suci, & Tannenbaum, 1957) and since each of the personality measures included in the survey has been shown to be psychometrically sound, there was no need for a pilot study involving the determination of test-retest reliability. Internal consistency reliability coefficients were calculated for the semantic differential factors and for each personality variable, i.e., empathy, locus of control, and social desirability. The SPSS reliability subroutine was used to obtain Cronbach's alpha reliability coefficients.

The Survey Instrument

The survey instrument consisted of: (a) four brief vignettes and the semantic differential rating scales that accompany these vignettes, (b) a scale measuring the responding therapists' levels of empathy, (c) a scale measuring locus of control, (d) a social desirability scale, and (e) a demographic and background data questionnaire. These measures are described in the paragraphs which follow.

The Vignettes

The four vignettes included in each survey instrument described the following four situations: (a) a family in which incest has occurred, (b) a family in which a child has been abused physically, (c) a family in which the father has little patience with a child who has been diagnosed as having an Attention Deficit Disorder with Hyperactivity (ADHD), and (d) a family in which the father does not accept the behavior of a teen-aged child who has been diagnosed as suffering from schizophrenia.

Although the focus of the proposed study was clearly on the situation in which incest has occurred, there were two important reasons for including the other vignettes in the survey. First, the inclusion of the additional vignettes provided a point of comparison to the case of incest. The use of the other vignettes allowed the investigator to determine whether therapists are more likely to attribute blame to victims of incest than they are to blame victims of physical abuse or to

blame individuals who are affected by ADHD or schizophrenia. Second, the vignettes depicting situations other than incest served as distracters to the responding therapists, so that they would not necessarily assume that the focus of the study was limited strictly to incest.

The effect of the gender of the victim was assessed by varying the gender of the principal character in the in each of the four vignettes. In one-half of the surveys, the incest victim and the child diagnosed with ADHD were described as male, while the victim of childhood physical abuse and the teenager diagnosed with schizophrenia were described as female. In the other half of the survey instruments, the incest victim and the child diagnosed with ADHD were described as female, while the victim of childhood physical abuse and the teenager diagnosed with schizophrenia were described as male. For each of the four situations described in the vignettes, this manipulation allowed the investigator to compare therapists' attributions of blame when a victim is female to attributions of blame when a victim is male.

In addition, male and female therapists were surveyed, so that the investigator would be able to test for the interaction of the gender of the therapist and the gender of the victim. It was anticipated that the convenience sampling procedure might yield a larger proportion of female therapists than male therapists.. It was decided that if the early returns indicated a preponderance of females, special efforts would be made to recruit males. As it turned out, this was not necessary.

The order of presentation of the four vignettes was counterbalanced, such that one-eighth of the respondents read the vignettes in each of the following orders:

(a) incest, physical abuse, ADHD, and schizophrenia; (b) physical abuse, ADHD, schizophrenia, and incest; (c) ADHD, schizophrenia, incest, and physical abuse; (d) schizophrenia, incest, physical abuse, and ADHD; (e) incest, ADHD, schizophrenia, and physical abuse; (f) ADHD, schizophrenia, physical abuse, and incest; (g) schizophrenia, physical abuse, incest, and ADHD; and (h) physical abuse, incest, ADHD, and schizophrenia. The four vignettes are described below.

The incest vignette. This vignette described the victim as a 14 year-old girl (or boy) who entered puberty around her (his) twelfth birthday. An older victim was selected for the purpose of the study, because it was felt that there would be a somewhat greater tendency for therapists to attribute some of the blame for the incest to an adolescent victim, as opposed to a young child.

The incest victim's father was described as having a problem with alcohol. There were two reasons for describing him in this manner. First, such a description was realistic, because perpetrators of incest are often substance abusers. Second, the alcohol problem might be viewed as a factor that could to some extent mitigate the blame attributed to the perpetrator.

The incestuous relationship was described as involving multiple instances of oral and genital (or anal) intercourse that took place over a period of nearly 2 years. No mention was made in the vignette of any use of force or intimidation. These aspects of the vignette had been included in order to allow the respondent the latitude to infer that the victim may have been to some extent a willing participant. In addition, it was assumed that the extended duration of the incestuous

involvement might lead respondents to assume that the victim's mother must have had knowledge of the situation.

The incest vignette described the mother as having had "suspicions" for some time before the victim formally disclosed the sexual involvement to her. This sentence has been included to allow the respondents to infer that the victim's mother may have consciously or unconsciously chosen to ignore the situation rather than confront it. Such an inference might be expected to lead respondents to place some of the blame for the situation on the mother.

The physical abuse vignette. This vignette also described the victim as a 14 year-old. The abusing father was described as having a "bad temper, especially after he has been drinking." The reference to possible alcoholism in this vignette has been included for the same reasons that it has been included in the incest vignette.

The physical abuse described in this vignette involved the father's slapping the adolescent in the face and striking the adolescent with his fist. The abuse was described as being sufficiently severe as to lead to bruises and black eyes, and the adolescent has been sufficiently embarrassed by these injuries to have stayed home from school.

The vignette indicated that the physical abuse had occurred sporadically over a 2-year period. No mention was made as to the mother's knowledge of the situation, since it seems clear that a mother would have to be aware that her adolescent daughter or son has been beaten.

The ADHD vignette. This vignette described a 14 year-old boy (or girl) who has been retained in grade twice because of poor academic achievement. The child

is described as having great difficulty in attending to school work and as being unable to control a tendency toward impulsive and hyperactive behavior.

The father, who used considerable caffeine and nicotine to keep himself moving at the hectic pace required by his very demanding work, felt that the child could control his (her) behavior if only he/she would "grow-up" and "get serious." He punished low performance on tests and report cards by grounding the child to his (her) room and assigning enforced study hours.

The schizophrenia vignette. This vignette described a precocious 14- year-old boy (girl) who had been behaving in a bizarre manner for the last several months. The teen was described as withdrawing from friends and school activities, and as heavily involved in reading concerned with UFOs, astrology, and the occult. Most recently the teen had complained of hearing voices that are not heard by other family members, and he (she) has been using alcohol to help to quiet these voices down.

The teen spent most of the day in the house, rarely got fully dressed, and had become increasingly disorganized and unkempt. A psychiatrist, seen at the request of the school psychologist, recently made the diagnosis of schizophrenia and prescribed medication in an effort to control the symptoms of psychosis. The father, a worrier who was overburdened with fears of being downsized from his company and faced the prospect of not meeting his financial obligations, refused to "give-in" to this definition of his son's (daughter's) problems and alternated between cajoling and demanding the child to "snap out of it" and get back into the swing of social activities and studies.

The Semantic Differential Rating Scales

After reading each vignette, the responding therapists were asked to rate each of three target individuals in the family on a series of 23 bipolar adjective pairs, as follows: (a) innocent...guilty; (b) good...bad; (c) clean...dirty; (d) healthy...sick;(e) weak...strong;(f) sad...happy;(g) large...small; (h) honest...dishonest; (i) delicate...rugged; (j) beautiful...ugly; (k) blameless...blameworthy; (l) tense...relaxed; (m) loud...quiet; (n) intact...damaged; (o) anxious...calm; (p) sociable...unsociable; (q) isolated...connected; (r) wrong...right; (s) responsible...not responsible; (t) fast...slow; (u) controlling...controlled; (v) active...passive; and (w) damaged...intact.

These adjective pairs were selected from among the adjective pairs created by Osgood et al. (1957) for use with their semantic differential technique. This technique has been described as an efficient procedure for assessing attitudes which is relatively nonreactive in nature (Kerlinger, 1972). Respondents rating a target individual on such paired adjectives tend to be relatively unaware of other dimensions along which they are rating that individual. This has the effect of reducing the tendency of subjects to respond in a socially desirable manner. Ratings are made on seven-point scales. Copies of the vignettes are presented in Appendix A.

Empathy

Empathy was measured by the Interpersonal Reactivity Index (IRI) (Davis, 1980). This was a 28-item self-report questionnaire that yielded subscale scores for ability to fantasize, perspective-taking, empathic concern, and personal distress. These dimensions of empathy were defined by Davis as follows: (a) Fantasizing was the

tendency of the respondent to identify strongly with fictitious characters in books, movies, or plays. (b) Perspective-taking was the ability or tendency of the respondent to adopt the perspective or point of view of other individuals. (c) Empathic concern was the tendency of the respondent to experience feelings of warmth, compassion, or concern for other individuals who are undergoing negative experiences. (d) Personal distress referred to the likelihood that the respondent will experience feelings of discomfort and/or anxiety when witnessing the negative experiences of others.

The four IRI subscales have been shown by the author to have acceptable internal consistency reliabilities among samples of female and male undergraduates. The alpha coefficients reported by Davis (1980) for the four subscales ranged from .61 to .79 for male undergraduates, and from .62 to .81 for female undergraduates.

Davis (1980) reported that the average score on all four subscales was higher among females than among males. The intercorrelations among the subscales ranged from -.29 to .33, indicating that the subscales measure distinct constructs. Evidence of the validity of the subscales has been provided in the form of significant correlations with other, theoretically related measures. For example, scores on perspective-taking have been shown to be a significant predictor of the respondent's ability to perceive other individuals accurately, and empathic concern has been shown to be related positively to the strength of one's emotional reaction to others (Juska, 1998). A copy of the IRI is presented in Appendix A.

Locus of Control

Locus of control was measured by the 29-item forced-choice Rotter Internal-External Locus of Control Scale (I-E Scale) (Rotter, 1966). This scale measured "subjects' expectations about how reinforcement is controlled" (Rotter, 1966, p. 10). Twenty-three of the items comprised the I-E Scale per se, and six items were fillers. Rotter reported internal consistency reliabilities for the scale for diverse norming groups ranging from .65 to .73. He also reported one-month test-retest reliabilities ranging from .60 to .83 for samples of undergraduates and prisoners. With respect to validity, Rotter (1966) reported a correlation of .60 ($p < .001$) between scores on the I-E Scale and scores on the previously developed James-Phares measure of locus of control. He also reported significant relationships for college students between scores on the I-E Scale and grade point average.

Social Desirability

Social desirability was measured by the 10-item version of the Marlowe-Crowne Social Desirability Scale (M-C SDS) (Crowne and Marlowe, 1960, 1964). The ten-item version of the scale (M-C 10) was modified from the original 30-item Marlowe-Crowne Scale by Strahan and Gerbasi (1972). The modified scale, like the original, employs a true-false response format. The true-false format was used, because it forces the respondent to make a choice between a socially desirable response and a socially undesirable response, without allowing the respondent any room to equivocate.

The modification was undertaken because several of the items in the original Marlowe-Crowne Social Desirability Scale were found to "contribute relatively little to

the overall meansure" (Strahan & Gerbasi, 1972, p. 191). Using the responses of 500 university students in two classes of an introductory psychology course, Strahan and Gerbasi performed a principal components analysis of the original M-C SDS. They used the results of this analysis to select the five positively worded items and five negatively worded items which had the highest loadings on the first principal component.

Strahan and Gerbasi (1972) reported internal consistency (Kuder-Richardson) reliability coefficients for the resulting scale ranging from .61 to .70 for four samples of male and female university students. A copy of the M-C 10 is presented in Appendix A.

Demographic and Background Characteristics

Survey items assessing the demographic and background characteristics of the responding therapists are presented in Appendix A.

Methods of Data Analysis

All the data were coded and keyed for analysis using the Statistical Package for the Social Sciences (SPSS) statistical analysis program. Attitude scores were obtained by factor analyzing responses to the paired bipolar adjective scales used to rate the family members in the incest vignette. A principal components analysis with varimax rotation was employed for this purpose. In order to preserve the independence of observations that is required for the factor analysis, the investigator employed the ratings assigned to the victim by one-half of the respondents, and the ratings assigned to the perpetrator by the other half of the respondents. Which set of ratings was taken from each respondent was determined randomly. The ratings assigned to the victim and to the

perpetrator were used, since it was felt that these ratings would maximize the variability of the ratings with respect attribution of blame.

Based on the factor solution obtained in the analysis of the ratings of the victim and perpetrator in the incest vignette, cluster scores were generated for attribution of blame for each respondent on each of the three target individuals described in each of the vignettes. In this way, the attribution of blame scores were made comparable across both the target individuals and the vignettes. This was particularly important because it enabled the investigator to compare the attributions of blame that were assigned to the victim, the perpetrator, and the victim's mother.

The first research hypotheses was tested by means of a four-way mixed model analysis of variance (ANOVA) in which the between groups factors were therapist gender and survey form (female victim versus male victim) and the within-groups factors were the stimulus individual being rated (victim, perpetrator, and victim's mother), and the vignette.

The dependent variable in this ANOVA was the cluster score which represented attribution of blame. Main and interaction effects that were significant at the .05 level were followed by post-hoc Scheffe' contrasts to determine the significance of pairwise differences between the target individuals depicted in the vignette.

Scale scores were obtained for each of the personality scales included in the survey, including the subscales of the IRI, and the Marlowe-Crowne Social Desirability Scale. Internal consistency reliability coefficients were computed for each of these scales. Any respondent omitting more than 10 % of the items for a given scale was assigned a missing value for the corresponding scale score. The value indicating that a

respondent does not have a valid score for a particular variable was 999. Any subject having a value of 999 for a given variable was excluded from all analyses employing that variable.

The second research hypothesis was concerned with the relationship between attributions of blame toward the victim of incest and the therapist experience and training factors. This hypothesis was tested by calculating and evaluating the significance of the Pearson correlations between attributions of blame to the victim of incest and each of the background variables. Each correlation was evaluated in a two-tailed test at the .05 level.

The third research hypothesis was concerned with the relationship between attributions of blame toward the victim of incest and the therapist personality variables, including the four dimensions of empathy measured by the IRI and scores on the Locus of Control Scale. This hypothesis was also tested by calculating and evaluating the significance of the Pearson correlations between attributions of blame to the victim of incest and each of the personality measures. These correlations were also evaluated in two-tailed tests at the .05 level of significance.

Chapter IV

Results

In this chapter the results of the study are reported. The results have been organized under five headings, as follows: (a) description of the sample, (b) factor analysis of semantic differential ratings, (c) effect of therapist gender on attributions of blame for incest to the victim, (d) relationships between the therapist's training and experience and attributions of blame for incest to the victim, and (e) relationships between the therapist personality characteristics of empathy and locus of control and attributions of blame for incest to the victim.

Description of the Sample

Table 1 presents the frequency distributions for the obtained sample of 202 therapists on gender, professional identification, highest degree, theoretical orientation, and exposure to preservice coursework and inservice training in incest. The sample contained 107 females (53.0%) and 95 males (47.0%). The modal category with respect to professional identification was social worker, representing 92 respondents (45.5%). The next most frequently represented professional group was counseling psychologist (25.2%), followed by clinical psychologist (14.4%) and school psychologist (7.9%). A total of 96 respondents

Table 1

Frequency Distributions of Responding Therapists' Gender, Professional Identification, Highest Degree, and Professional Orientation (N = 202)

Variable	Value	*n*	%
Gender	female	107	53.0
	male	95	47.0
Professional Identification	social worker	92	45.5
	clinical psychologist	29	14.4
	counseling psychologist	51	25.2
	psychiatrist	6	3.0
	school psychologist	16	7.9
	counselor	8	4.0
Highest Degree	masters degree	99	49.0
	doctoral degree	103	51.0
Theoretical Orientation	ego psychology	28	13.9
	object relations	43	21.3
	cognitive	30	14.9
	family systems	14	6.9
	psychodynamic	7	3.5
	behavioral	53	26.2
	psychoanalytic	27	13.4

Table 1 (continued)

Variable	Value	*n*	%
Preservice coursework			
On Incest?	yes	105	52.0
	no	97	48.0
Inservice Training on			
Incest?	yes	41	20.3
	no	161	79.7

(47.5%) fell into one of these three groups of psychologists. Eight respondents described themselves as counselors (4.0%), and six described themselves as psychiatrists (3.0%).

The sample was divided almost evenly between respondents who indicated that they held doctoral degrees (51%) and those who indicated that the master's degree was their highest degree (49.0%). With respect to theoretical orientation, the modal response category was behavioral (26.2%). This category was followed by object relations (21.3%), cognitive (14.9%), ego psychology (13.9%), and psychoanalytic (13.4%). Fewer respondents indicated that their orientation was family systems (6.9%) or psychodynamic (3.5%). The majority of the respondents (52.0%) fell into one of the four closely related theoretical orientations of object relations, ego psychology, psychoanalytic, and psychodynamic.

One hundred and five of the respondents (52.0%) indicated that they had preservice coursework concerned with incest. Forty-one respondents (20.3%) indicated that they had been exposed to inservice training on incest.

Respondents also indicated their age in years and the number of years of experience they had as therapists. Descriptive statistics were obtained on these interval scale variables. Self-reported age ranged from 24 to 58, with a mean of 39.7 years ($SD = 9.7$). Years of experience ranged from 1 year to 25 years. The mean number of years of experience in the sample was 12.0 ($SD = 6.9$).

Preliminary Factor Analyses of Semantic Differential Ratings

Preliminary analyses of the semantic differential ratings were carried out to determine the extent to which the ratings yielded similar attitude dimensions across the 12 combinations of vignette (incest, physical abuse, ADHD, and schizophrenia) and target individual being rated (victim, father of victim, mother of victim). A principal components analysis with varimax ratings was applied to each of these 12 sets of ratings. The initial factor solutions for these analyses had from 4 to 6 factors that had eigenvalues greater than 1.00, but in each case the skree criterion and the loadings of the factors in the rotated factor matrices suggested that the first four factors were interpretable. Accordingly, the analyses were rerun specifying four-factor solutions. The rotated factor matrices for these solutions are presented in Appendix B.

These solutions were quite similar. In each solution, a clear factor representing blame emerged, and in 10 of the 12 analyses, all four of the adjective pairs considered most indicative of attribution of blame loaded heavily (absolute

value of .50 or above) on the blame factor. These pairs were #11 (blameless...blameworthy), #16 (innocent...guilty), #18 (wrong...right), and #19 (responsible...not responsible). In addition, in all 12 of the analyses, three additional factors emerged that were named: (a) evaluation, (b) psychosocial adjustment, and (c) potency/health. These factors did not appear in the same order from one analysis to the next; but the blame factor was either the first or second strongest factor, as indicated by the magnitude of the eigenvalues, in all but one of the 12 analyses. Thus it appeared that the adjective pairs assessed common domains across the 12 vignettes by target individual combinations, and that attribution of blame was the strongest domain.

Factor Analysis Used to Generate Attribution of Blame Scores

Factor analysis was used to confirm that the semantic differential ratings made by therapists yielded the required measure of attribution of blame for the incest to the victim and to the perpetrator. In order to maximize variability in the ratings subjected to the factor analysis, the ratings assigned to the victim in the incest vignette were employed for one-half of the sample, and the ratings assigned to the perpetrator in the incest vignette were employed for the other half of the sample. A principal components analysis was applied to the 23 semantic differential rating scales, and the varimax rotation with the Kaiser normalization was employed.

The analysis yielded six factors having eigenvalues greater than 1.00, but the skree criterion and the loadings in the rotated six-factor solution indicated that only the first four factors were clear and reliable. The eigenvalues for the six factors were 7.06, 3.82, 2.78, 2.05, 1.60, and 1.06 for factors one through six, respectively. Based on the

results obtained in the six-factor solution, the analysis was rerun specifying a four-factor solution. The four factors extracted in this second analysis together explained 68.3% of the variability in the item set.

Table 2 presents the rotated component matrix for this analysis. On the basis of the loadings displayed in this matrix, the four factors were named. The first factor loaded heavily on dishonest (.82), dirty (.80), ugly (.80), unsociable (.71), rugged (.62), bad (.55), and sick (.49). This was clearly the evaluative factor that often emerges in semantic differential research (Osgood et al., 1957). In this case, it was a negative evaluation factor. That is, higher scores on this factor signified a more negative perception of the stimulus individual being rated by the responding therapist. The second factor loaded heavily on guilty (.92), blameworthy (.90), not responsible (-.85), and right (-.65). This was the attribution of blame factor that we hoped would emerge in the therapist's ratings of the incest victim and the perpetrator. Higher scores on this factor for a given stimulus individual signified greater attribution of blame to that individual by the responding therapists. The third factor loaded heavily on happy (.84), relaxed (.77), calm (.71), connected (.65), damaged (-.65), strong (.53), and intact (.49). This factor appeared to measure the respondent's perception of the stimulus individual as being well-adjusted or having a strong sense of well-being. Higher scores on this factor signified higher levels of adjustment. Finally, the fourth factor loaded heavily on small (.88), slow (.74), controlled (.62), passive (.53), and quiet (.43). This was clearly the potency factor that often emerges in semantic differential research. The factor was weighted so that higher scores on the factor signified a perception that the stimulus individual being rated is perceived as lacking power or potency.

Table 2

Rotated Component Matrix for Four-Factor Solution of Semantic Differential Ratings of Incest Victim and Perpetrator

Item	Component 1	2	3	4
1. sociable.....unsociable	.71[a]	.13	-.28	.09
2. large.....small	-.07	-.19	-.03	.88[a]
3. clean.....dirty	.80[a]	.35	-.08	-.01
4. healthy..... sick	.49[a]	.48	.30	-.23
5. good.....bad	.55[a]	.46	.18	.32
6. sad.....happy	-.21	-.03	.84[a]	-.03
7. weak.....strong	.05	-.47	.53[a]	-.36
8. honest.....dishonest	.82[a]	.04	.03	-.29
9. delicate.....rugged	.62[a]	-.22	.08	-.33
10. beautiful.....ugly	.80[a]	.15	.02	-.18
11. blameless.....blameworthy	.20	.90[a]	.04	-.26
12. tense.....relaxed	.01	.34	.77[a]	.13
13. loud.....quiet	-.27	-.25	.21	.43[a]
14. intact.....damaged	-.36	.35	-.65[a]	-.17
15. anxious.....calm	.11	-.11	.71[a]	-.29

Table 2 (continued)

Item	Component 1	2	3	4
16. innocent.....guilty	.11	.92$_a$	-.05	-.19
17. isolated.....connected	-.17	.04	.65$_a$	-.01
18. wrong.....right	-.09	-.65$_a$	.16	.51
19. responsible.....not responsible	-.18	-.85$_a$	-.03	.34
20. fast.....slow	.00	-.29	-.08	.74$_a$
21. controlling.....controlled	-.54	-.24	-.17	.62$_a$
22. active.....passive	-.34	-.37	-.50	.53$_a$
23. damaged.....intact	.42	.01	.49$_a$	.25

Note. $_a$ The largest loading of each item across the four factors.

Thus the domains represented by the four factors were unambiguous, and the second factor was appropriate for testing the research hypotheses, which had to do with the attribution of blame to victim and perpetrator. Cronbach's alpha internal consistency reliability coefficients were calculated for cluster scores formed for the four factors by summing the items having their highest loadings on each of the four factors. These coefficients were .84 for negative evaluation, .95 for attribution of blame, .80 for well-being, and .82 for lack of potency.

Cluster scores were obtained for the attribution of blame factor for the purpose of testing the three research hypotheses. Cluster scores were obtained for attribution of

blame for each of the three target individuals (victim, father/perpetrator, and mother) in each of the four vignettes.

Effect of Therapist Gender on Attributions of Blame

The first research hypothesis specified that there would be no significant main effect due to therapist gender on the tendency to attribute blame to the victim of incest. However, the hypothesis specified further that there would be a significant interaction between the gender of the responding therapist and that of the victim, such that male therapists would be more likely than female therapists to attribute blame to a female victim, whereas female therapists would be more likely than male therapists to attribute blame to a male victim. This hypothesis was not confirmed.

The hypothesis was tested by a four-way mixed model analysis of variance (ANOVA) in which the between groups factors were therapist gender and survey form (female victim versus male victim), and the within groups factors were vignette (incest, physical abuse, ADHD, schizophrenia) and stimulus individual rated (victim, victim's father, victim's mother). In order to control for social desirability, consideration was given to performing an analysis of covariance (ANCOVA), employing social desirability as the covariate. However, preliminary analyses indicated that the correlation between the social desirability scale and the cluster score representing attribution of blame to the victim was weak and nonsignificant (r = .13, n.s.). Elashoff (1969) and Huitema (1980) recommended not employing a variable as a covariate if the observed correlation between the covariate and the dependent variable is less than .30. Therefore, the ANCOVA was unnecessary.

Several results of the ANOVA could lead to a confirmation of the hypothesis: A significant three-way interaction of therapist gender by gender of victim by stimulus individual rated, in the absence of significant four-way interaction, could indicate a general tendency for male therapists to attribute relatively greater blame to female victims and a tendency for female therapists to blame male victims, regardless of the nature of the problem. A significant four-way interaction of therapist gender by victim gender by stimulus individual by vignette could indicate a tendency for male therapists to blame female victims and for female therapists to blame male victims, but for the incest situation only.

The ANOVA summary table for this analysis is presented in Table 3. The data in Table 3 indicated that the three-way interaction of gender of responding therapist by gender of victim by stimulus individual rated was not significant $F(3, 396) = 0.49, p = .614$, nor was the four-way interaction significant $F(6, 1188) = 0.33, p = .924$. These findings did not support the research hypothesis.

Table 4 presents the mean scores on attribution of blame for incest assigned to each of the three stimulus individuals by female and male therapists when the victim was a female and when the victim was a male. The data in Table 4 indicated that, contrary to expectation, female therapists and male therapists alike attributed greater blame for incest to male victims than to female victims. The mean blame score assigned to the incest victim by female

Table 3

Summary Table for Analysis of Variance of Attribution of Blame Scores by Therapist Gender, Victim Gender, Vignette, and Stimulus Individual

Source	*SS*	*df*	*MS*	*F*	*p*
Between-Subjects Effects					
Therapist Gender (A)	301.3	1	301.3	3.38	.068
Victim Gender (B)	284.9	1	284.9	3.19	.075
(A) x (B)	45.7	1	45.7	0.51	.475
Error	17669.4	198	89.2		
Within-Subjects Effects					
Vignette (C)	2108.0	3	702.7	28.06	.000***
(C) x (A)	87.5	3	29.2	1.16	.322
(C) x (B)	107.2	3	35.7	1.42	.234
(C) x (A) x (B)	105.2	3	35.1	1.40	.242
Error (Vignette)	14875.9	594	25.0		
Stimulus (D)	35657.7	2	17828.9	316.25	.000***
(D) x (A)	580.1	2	290.1	5.15	.006**
(D) x (B)	217.8	2	108.9	1.93	.146
(D) x (A) x (B)	55.0	2	27.5	0.49	.614
Error (Stimulus)	22324.8	396	56.4		
(C) x (D)	15421.5	6	2570.2	94.06	.000***

Table 3 (continued)

Source	*SS*	*df*	*MS*	*F*	*p*
(C) x (D) x (A)	557.6	6	92.9	3.40	.002**
(C) x (D) x (B)	748.7	6	124.8	4.56	.000***
(C) x (D) x (B) x (A)	53.2	6	8.9	0.33	.924
Error (C) x (D)	32462.9	1188	27.3		

Note. $^{**}p < .01$. $^{***}p < .001$.

Table 4

Attribution of Blame for Incest to Victim, Victim's Father (Perpetrator), and Victim's Mother by Female and Male Therapists when Victim is Female or Male

	Female Therapists(a)				Male Therapists(b)			
	Female Victim		Male Victim		Female Victim		Male Victim	
	($n = 60$)		($n = 47$)		($n = 40$)		($n = 55$)	
Person Rated	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Victim	13.9	8.1	15.4	9.1	11.4_a	7.5	15.5_a	8.9
Father (Perpetrator)	20.7	8.0	17.9	7.9	25.0_a	5.9	19.6_a	8.3
Mother	18.3	7.4	16.9	8.2	19.2	7.4	18.7	8.7

Note. $_a$ denotes means in each row differ significantly. $^{*}p < .05$.

respondents was 1.5 points higher for male victims than for female victims (M = 15.4 vs. 13.9). This difference was not statistically significant. Among responding male therapists, the mean blame score assigned to the incest victim was 4.1 points higher for male victims than for female victims (M = 15.5 vs. 11.4). This difference was statistically significant ($p < .05$). This pattern was different from the hypothesized pattern, which envisioned male therapists blaming female victims more than male victims, while female therapists would blame male victims more than female victims. In actuality, both male and female therapists blamed male incest victims more.

In addition, male respondents tended to attribute greater blame for incest to the victim's father, the perpetrator, than did female therapists. The male respondents blamed the perpetrator more than the female respondents when the victim was female (M = 25.0 vs. 20.7), as they did when the victim was male (M = 21.1 vs. 17.9). Each of these differences was significant ($p < .05$). Among the male therapists, the difference between the mean score for attribution of blame to the victim's father was significantly ($p < .05$) higher when the victim was female (M = 25.0) than when the victim was male (M = 19.6). The corresponding difference among female therapists (M = 20.7 vs. 17.9) was not significant.

The mean attribution of blame score assigned by male therapists to the mothers of female victims was 19.2, compared to a mean blame score of 18.3 assigned by females to the mothers of female victims. This difference was not significant. The mean attribution of blame score assigned by male therapists to the mothers of male victims was 18.7, compared to a mean of 16.9 assigned by females to the mothers of male victims. This difference was not statistically significant either.

Several significant effects were obtained in the ANOVA on attribution of blame scores that were in line with expectation. There was a significant main effect due to vignette $F(3, 594) = 28.06, p = .000$. This effect reflected the higher mean attribution of blame scores assigned in the incest vignette ($M = 17.8$) and in the physical abuse vignette ($M = 17.8$) than in the ADHD vignette ($M = 16.8$) or the schizophrenia vignette ($M = 15.5$). Post-hoc contrasts indicated that the means of the incest vignette and the physical abuse vignette were both significantly ($p < .05$) higher than the mean for the schizophrenia vignette, but they did not differ significantly from the mean of the ADHD vignette. There was also a significant main effect due to the stimulus individual being rated $F(2, 396) = 316.25, p = .000$. The mean attribution of blame rating assigned to the victim was 11.70, that assigned to the victim's father was 21.0, and the mean assigned to the victim's mother was 18.2. Post-hoc contrasts indicated that all three pairwise mean comparisons of the stimulus individuals were significant.

There was a significant interaction of therapist gender by stimulus individual being rated $F(2, 396) = 5.15, p = .006$. This interaction was reflected in part in the means presented in Table 4. Post-hoc comparisons indicated that the mean difference between attributions of blame toward the father (perpetrator) and those toward the victim was significantly ($p < .05$) greater among the responding male therapists than among the responding female therapists. There was also a significant interaction of vignette by stimulus individual being rated $F(6, 1188) = 94.06, p = .000$. This interaction reflected significantly ($p < .05$) greater discrepancies between attributions of blame toward father and victim in the incest and physical abuse vignettes than in the ADHD and schizophrenia vignettes.

The ANOVA presented in Table 3 yielded a significant three-way interaction of therapist gender by stimulus individual by vignette $F(6, 1188) = 3.40$, $p = .002$. The marginal means pertinent to this interaction are presented in Table 5. These means indicated that the tendency to blame the victim of incest was greater among female therapists ($M = 14.5$) than among male therapists ($M = 13.8$). In contrast, the tendency to blame the perpetrator father in the incest vignette was greater among male therapists ($M = 22.7$) than among female therapists ($M = 19.5$). A contrast comparing the difference between the ratings assigned to the incest victim by male and female therapists to the difference between the ratings assigned to the perpetrator by male and female therapists was significant ($p < .01$). This pattern was different from the pattern of means observed in the physical abuse vignette. In that vignette, female and male therapists were similar with respect to the blame assigned to the victim ($M = 6.7$ and 7.1, respectively) and to the father ($M = 26.9$ and 26.4, respectively). Neither of these mean differences was significant.

The ANOVA presented in Table 3 also yielded a significant three-way interaction of gender of victim by stimulus individual by vignette $F(6,1188) = 4.56$, $p < .001$. The means pertinent to this interaction are presented in Table 6. These means indicated that the tendency to blame a victim of incest was greater when the victim was a male ($M = 15.5$) than when the victim was a female ($M = 12.9$). In contrast, the tendency to blame the perpetrator father was greater when the victim was female ($M = 22.4$) than when the victim was male ($M = 19.6$). These relationships were both significant at the .05 level.

Table 5

Attribution of Blame for Incest to Victim, Victim's Father (Perpetrator), and Victim's Mother by Male and Female Therapists in Each of Four Vignettes

	Vignette							
	Incest		Physical Abuse		ADHD		Schizophrenia	
Person Rated / Therapist Gender	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Victim								
male ($n = 95$)	13.8_a	8.5	7.1	2.3	12.4	3.8	12.4	8.9
female ($n = 107$)	14.5_a	8.6	6.7	2.4	13.8	3.9	13.1	5.4
Father (Perpetrator)								
male	22.7_a	7.7	26.4	2.1	19.7	7.3	17.8	7.1
female	19.5_a	8.1	26.9	1.5	18.3	5.8	15.9	7.2
Mother								
male	18.9	8.2	20.8	5.3	18.0	5.7	16.9	5.5
female	17.7	7.8	18.7	6.6	18.0	4.2	16.6	6.0

Note. $_a$ denotes means pertaining to victim and perpetrator of incest differ significantly.
$p < .05$.

Table 6

Attribution of Blame for Incest to Victim, Victim's Father (Perpetrator), and Victim's Mother when Victim is Male and Female in Each of Four Vignettes

	Vignette							
	Incest		Physical Abuse		ADHD		Schizophrenia	
Person Rated / Victim Gender	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Victim Rated								
male victim ($n = 95$)	15.4_a	8.9	6.8	2.4	12.6	4.1	12.0	5.8
female victim ($n = 107$)	12.9_a	8.0	6.9	2.4	13.7	3.6	13.4	5.8
Father (Perpetrator) Rated								
male victim	19.6_a	8.3	26.6	2.0	18.5	6.8	16.5	8.1
female victim	22.4_a	7.5	26.7	1.7	19.4	6.3	17.2	6.2
Mother								
male victim	17.9	8.5	19.9	6.2	17.5	5.9	16.3	6.6
female victim	18.7	7.4	19.4	6.0	18.5	3.7	17.2	4.8

Note. $_a$ denotes means pertaining to victim and perpetrator of incest differ significantly.
$p < .05$.

This pattern was also quite different from that observed in the physical abuse vignette. In that vignette female and male victims had similar mean blame scores (M = 6.9 and 6.8, respectively). Mean blame scores assigned to the perpetrator were also similar for female and male victims (M = 26.7 and 26.6, respectively).

Parallel analyses of variance were performed on scores on the other three factors that emerged from the semantic differential ratings, i.e, the negative evaluation factor, the psychological well-being factor, and the lack of potency factor. In none of these analyses was there a significant three-way interaction of gender of therapist by gender of victim by stimulus individual rated, and in none of these analyses was there a significant four-way interaction. Predictably, these analyses indicated that victims' fathers were rated significantly ($p < .05$) higher than victims on negative evaluation, and that victims and victims' mothers were rated significantly ($p < .05$) higher on the lack of potency factor than were the victims' fathers.

Attribution of Blame in Relation to Therapist Training and Experience

The second research hypothesis stated that the therapists' attributions of blame toward the victim of incest would be related negatively to several aspects of the therapist's experience and training, namely: (a) years of experience, (b) specific experience treating victims of sexual abuse, (c) exposure to preservice education on incest, (d) overall level of education, and (e) exposure to inservice education on incest. In order to test this hypothesis, Pearson correlations were calculated between scores on attribution of blame to the victim and each of the background factors. These correlations are presented in Table 7. The correlations indicated that the hypothesis

Table 7

Pearson Correlations Between Therapist Experience and Training Factors and Attributions of Blame Toward Victim, Victim's Father, and Victim's Mother

	Correlation with Attribution of Blame Toward		
	Victim	Victim's Father	Victim's Mother
Experience/Training Factor	*r*	*r*	*r*
Years of Experience	-.53***	.30***	.30***
Have Worked with Sexually Abused	-.16*	.20**	.42***
Preservice Course on Incest	-.19**	.17*	-.16*
Highest Degree	.04	.08	.16*
Inservice Training on Incest	-.07	.44***	.05

Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

was confirmed in part. Attribution of blame toward the victim of incest was related negatively to the respondent's total years of professional experience ($r = -.53$, $p = .000$), prior experience working with victims of sexual abuse ($r = -.16$, $p = .022$), and exposure to one or more preservice courses on incest ($r = -.19$, $p = .006$). These significant correlations were in the expected directions. More experienced therapists, therapists who have had experience working with victims of sexual abuse, and therapists who reported

having had preservice coursework on incest were relatively unlikely to attribute blame for incest to the victim. Attributions of blame toward the victim were not related significantly to the responding therapist's highest degree or to the therapist's exposure to inservice education on incest.

Also presented in this table are the correlations between the therapist experience and training factors and the attributions of blame they assigned to the victims' fathers and mothers. Attributions of blame toward the father of the incest victim (the perpetrator) were related positively to the responding therapist's number of years of experience (r = .31, p = .000), the respondent's having had previous experience working with victims of incest (r = .20, p = .005), the respondent's having had preservice coursework on incest (r = .17, p = .013), and the respondent's exposure to inservice training on incest (r = .44, p = .000). More experienced therapists, therapists with specific experience working with sexually abused clients, therapists who had preservice coursework on incest, and therapists who reported that they had inservice training on incest were relatively likely to attribute blame to the father. The tendency to attribute blame to the victim's father was not related significantly to the respondent's highest degree.

Attributions of blame toward the incest victim's mother were also related positively to the years of experience of the responding therapist (r = .30, p =.000), and to prior experience working with sexually abused clients (r = .42, p = .000). In addition, the tendency to attribute blame to the victim's mother was related negatively to exposure to preservice courses on incest (r = -.16, p = .023), and positively to the respondent's highest degree (r = .16, p = .025). Therapists with preservice coursework on incest

tended to place relatively little blame on the victim's mother. Therapists with higher degrees tended to place greater blame on the mother of the incest victim.

The question of possible interactive effects of the therapist experience and training factors on the assignment of blame for incest to the victim, her father (perpetrator), and her mother was addressed by several additional analyses. First, the matrix of zero-order correlations among the five experience factors was obtained to determine whether any significant relationships existed among these factors. These correlations are presented in Table 8.

These correlations indicated several significant relationships among the therapist experience and training factors. Years of experience was related significantly to both prior experience working with the sexually abused ($r = .28, p < .001$) and highest degree ($r = .36, p < .001$). In addition, prior experience working with sexually abused clients was related to exposure to preservice courses on incest ($r = .49, p < .001$) and to exposure to inservice training in incest ($r = .59, p < .001$). Experience working with sexually abused clients was related negatively to highest degree ($r = -.16, p = .026$). Preservice exposure to one or more courses on incest was related positively to highest degree ($r = .19, p = .008$). Preservice and inservice training in incest were also related positively ($r = .17, p = .019$). These extensive intercorrelations among the experience and training factors suggested that there may be interactive effects on the attribution of blame to the victim, her father (the perpetrator), and her mother.

Accordingly, multiple regression analyses were run to determine the effects of each training and experience factor on each measure of attribution of blame, while

Table 8

Intercorrelations Among Five Therapist Experience and Training Factors

	Correlation with:			
	B	C	D	E
Experience/Training Factor:	*r*	*r*	*r*	*r*
Years of Experience (A)	.28***	.06	.36***	.09
Have Worked with Sexually Abused (B)	--	.49***	-.16*	.59***
Preservice Course(s) on Incest (C)		--	.19**	.17*
Highest Degree (D)			--	-.02
Inservice Training on Incest (E)				--

Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

controlling for the other predictors. Standardized regression coefficients were obtained for all predictors introduced at each step. These coefficients indicated the amount of change in attribution of blame associated with a change of one standard deviation unit in the predictor, and a test for the significance of each beta indicates whether that predictor is uniquely explaining significant variability in attribution of blame (Stevens, 1996). In the multiple regression of attribution of blame to the victim on the five predictors, years

of experience had a significant unique effect on attribution of blame ($\beta = -.66, p < .001$), as did exposure to preservice coursework on incest ($\beta = -.26, p < .001$). These multivariate coefficients were very similar to the results obtained in the zero order correlations. In the multiple regression analysis, the unique effect of prior inservice training in incest was not significant ($\beta = .04, p = .606$). This result was also similar to the finding obtained in the zero-order correlations, where prior inservice training was also nonsignificant.

However, the results obtained with respect to two of the predictors in the multiple regression of attributions of blame toward the victim were different from the results obtained in the zero-order correlations. Whereas the experience of having worked with sexually abused clients had been a significant predictor of attributions of blame toward the victim in the zero-order correlations, it fell to nonsignificance following the extraction of variability due to the remaining predictors ($\beta = -.158, p = .096$). Also, whereas highest degree was not a significant predictor of attribution of blame toward the victim as a zero order correlation, it was significant after variability due to the other predictors had been partialled out ($\beta = .206, p = .001$). The latter finding suggested that respondents who have obtained doctoral degrees without taking preservice courses on incest or inservice training regarding incest may be more inclined to blame the victim than respondents without exposure to such training who have not earned a doctorate. This would indicate that those who avoid such training experiences during the course of their education may be more inclined to blame the victim for incest.

Thus there were some interactions among the predictors which had an impact on the results when multivariate techniques were employed. This was also illustrated by the

fact that the strongest zero-order correlation of any one predictor with attribution of blame to the victim was -.53 (for years of experience), whereas the multiple correlation obtained in the regression analysis was .62.

In the regression predicting attribution of blame to the perpetrator of the incest (the victim's father) from the five training and experience variables, the unique effect of years of experience was significant ($\beta = .467, p < .001$), as was the unique effect of exposure to preservice courses on incest ($\beta = .552, p < .001$). These results were similar to the corresponding zero-order correlations. The experience of working with victims of sexual abuse was related positively to attribution of blame to the perpetrator after the effects of the other predictors were partialled ($\beta = .628, p < .001$). This result was also similar in direction to the corresponding zero-order correlation.

Differences between the zero-order correlations and the beta weights in the regression analysis were observed on exposure to inservice training on incest and highest degree. Whereas inservice training had been related positively and significantly to attribution of blame to the perpetrator in the zero-order correlations, this relationship was not significant after variability due to the other four predictors had been partialled out ($\beta = .12, p = .092$). The direction of this relationship did not change, but the magnitude of the relationship dropped to a nonsignificant level. With respect to highest degree, a nonsignificant predictor in the zero order correlations, the multiple regression analysis yielded a significant result ($\beta = .121, p = .036$).

Here again, then, there were some interactions among the predictors that were revealed in the multivariate analysis. The strongest zero-order correlation of any one

predictor with attribution of blame to the perpetrator was .44 (for inservice training). In contrast, the multiple correlation in the regression analysis was .69.

Finally, with respect to attribution of blame for incest to the mother of the victim, the unique effect of years of experience was significant ($\beta = .465$, $p < .001$). This result was similar in direction and magnitude to the corresponding zero-order correlation. The unique effect of experience working with sexually abused clients was also significant ($\beta = .594$, $p < .001$). This finding also was similar in direction and magnitude to the corresponding zero-order correlation.

There were differences between the zero-order correlations and the partial correlations obtained in the regression analysis on the other three predictors of attribution of blame for the incest to the victim's mother. Whereas the zero-order correlations yielded a significant positive relationship between preservice course(s) on incest and attribution of blame to the mother, the unique effect of preservice courses in the multiple regression analysis was nonsignificant ($\beta = .125$, $p = .117$). Whereas highest degree was a significant predictor of attributions of blame toward the victim's mother in the zero-order correlations, the unique effect of highest degree was not significant in the multiple regression analysis ($\beta = .100$, $p = .149$). Finally, whereas the zero-order correlation between inservice training on incest and attribution of blame to the mother was not significant, the unique effect of inservice training in the multiple regression analysis was significant ($\beta = .319$, $p < .001$).

Thus, on attribution of blame to the victim's mother as well as attribution of blame to the victim and the perpetrator of the incest, there were interactions among the predictors. The strongest zero-order correlation between attribution of blame to the

mother and any one predictor was -.42 (with experience working with sexually abused clients). The multiple correlation in the regression analysis was .49.

In summary, the most important therapist characteristics that appeared to be associated with the tendency not to blame the victim appeared to be experience and preservice coursework on sexual abuse. These same two therapist characteristics were associated with the tendency to assign blame to the victim's father (perpetrator). Years of experience was also related positively to the tendency of the therapist to blame the victim's mother.

Attributions of Blame in Relation to Therapist Empathy and Locus of Control

The third research hypothesis specified that there would be significant relationships between attributions of blame toward the victim and the therapist personality characteristics of empathy and locus of control. It was expected that therapists with greater empathy would be less likely to attribute blame to the victim of incest than those with lower levels of measured empathy. It was also expected that therapists with a relatively internal locus of control would be less likely than those with a more external locus of control to attribute blame for incest to the victim.

Empathy was measured in this study by the Interpersonal Reactivity Index (IRI) (Davis, 1996) a measure having four seven-item subscales that measure three different dimensions of empathy. These were fantasy, empathic concern, perspective-taking, and personal distress. Cronbach's alpha internal consistency reliability coefficients were obtained for each of these four subscales using the data from the research sample. The obtained reliability coefficients were .88, .91, .82, and .87, respectively. Locus of

Control was measured by the Rotter Locus of Control Scale. The calculated value of Cronbach's alpha for this scale, based on the study sample, was .84. On the Rotter I-E Scale, higher scores signified a more internal locus of control. Table 9 presents descriptive statistics for the four IRI Empathy subscales and for the Rotter Locus of Control Scale.

The third hypothesis was tested by calculating the Pearson Correlations between the measure of attribution of blame toward the victim and the measures of empathy and locus of control. These correlations are presented in Table 10. These correlations showed that the research hypothesis was confirmed in part.

Table 9

Descriptive Statistics on IRI Empathy Subscales (N = 202)

Therapist Personality Factor	minimum	maximum	*M*	*SD*
IRI-Fantasy	8.00	33.00	19.82	7.47
IRI-Empathic Concern	13.00	35.00	27.84	7.12
IRI-Perspective-Taking	14.00	34.00	25.13	5.45
IRI- Personal Distress	7.00	26.00	13.27	5.56
Locus of Control	26.00	42.00	36.21	4.24

Table 10

Pearson Correlations Between Therapist Personality Factors and Attributions of Blame Toward Victim, Victim's Father, and Victim's Mother

	Correlation with Attribution of Blame Toward		
Therapist Personality Factor	Victim *r*	Victim's Father *r*	Victim's Mother *r*
IRI-Fantasy	-.33***	.10	.35***
IRI-Empathic Concern	-.32***	-.02	.11
IRI-Perspective Taking	-.15*	-.09	.22***
IRI-Personal Distress	.07	.11	.44***
Locus of Control	-.09	.19**	.29***

Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

With respect to attributions of blame toward the victim, three of the five correlations were significant and in the expected direction. Therapist attribution of blame to the victim of incest was related negatively to the therapist's scores on the IRI-Fantasy subscale ($r = -.33$, $p = .000$), the IRI-Empathic Concern subscale ($r = -32$, $p = .000$), and the IRI-Perspective Taking Scale ($r = -.15$, $p = .040$). Nonsignificant relationships were observed between attribution of blame to the victim of incest and both the IRI-Personal Distress subscale and the Rotter Locus of Control Scale.

Also presented in this table are the correlations between these therapist personality factors and attributions of blame toward the incest victim's father and mother. The tendency to attribute blame for incest to the father of the victim (perpetrator) was not related significantly to any of the IRI subscales measuring empathy, but a significant positive relationship was observed between attribution of blame to the father and the responding therapist's measured locus of control ($r = .19, p = .008$). Those therapists having a more internal locus of control tended to blame the perpetrator more.

The tendency to attribute blame to the mother of the incest victim was related positively to three of the four IRI empathy subscales: the IRI Fantasy subscale ($r = .35$, $p = .000$), the IRI Perspective Taking subscale ($r = .22, p = .001$), and the IRI Personal distress subscale ($r = .44, p = .000$). Therapists with greater measured empathy tended to attribute more blame to the mother of the incest victim. In addition, the tendency to attribute blame to the mother of the incest victim was related positively to the Rotter Locus of Control Scale ($r = .29, p = .000$). Therapists having a more internal locus of control were more likely to attribute blame to the mother of the incest victim.

Summary

Therapist gender was not related to attributing blame for incest to the victim in the manner that was anticipated. There was no significant interaction between therapist gender and victim gender with respect to attribution of blame for incest to the victim of the incest. It had been expected that male therapists would tend to place greater blame on a female victim than on a male victim, whereas female therapists would tend to place greater blame on a male victim than on a female victim. In fact, male therapists tended to

place greater blame on a male victim than on a female victim; and among female therapists the difference between the mean blame scores assigned to female victims and to male victims did not differ significantly.

More experienced therapists, therapists who reported having experience working with the sexually abused, and therapists who had preservice coursework on incest were less likely than other therapists to blame the victim.

The therapist's level of empathy was generally related negatively to the likelihood of attributing blame to the victim of incest. The therapist's locus of control was not related significantly to the tendency to blame the victim for incest.

Chapter V

Discussion

The study reported here was carried out to identify key factors predicting the extent to which a therapist will tend to attribute blame for incest to the victim of that incest. The investigator recognized that therapists would most likely be unaware of any tendency they might have to blame a victim for incest. She also recognized that to the extent that responding therapists were aware of such a tendency, they would most likely be influenced by social desirability considerations to minimize their reports of this characteristic. Accordingly, the study employed the relatively nonreactive semantic differential technique (Osgood et al., 1957) to identify and measure the dimensions therapists used to conceptualize the victim, as well as the victim's father (the perpetrator of the incest), and the victim's mother. According to Kerlinger (1972), the semantic differential technique can be used to measure attitudes held by respondents without the respondents ever knowing exactly what those attitudes might be.

The decision to employ the semantic differential technique to assess therapist attitudes toward an incest victim implied that the first step in the analysis of the data was the use of a factor analysis of the semantic differential items to identify the attitude dimensions implicitly used by therapists to evaluate the victim. The results of this factor analysis will be considered first in this discussion. Next, the mean ratings assigned by therapists on attribution of blame will be considered, so as to provide a sense of the extent to which the responding therapists blamed the victim, the perpetrator, and the victim's mother. Following this discussion of the mean attribution of blame scores, the

results of the study obtained with respect to each of the three research hypotheses will be discussed in relation to the literature. The final sections of this chapter consider the implications of the study for preservice and inservice training, and recommendations for future research.

Dimensions along which Therapists Conceptualize and Evaluate the Victim, the Perpetrator, and the Victim's Mother

In order to identify the attitude dimensions employed by therapists in conceptualizing the victim of incest, the perpetrator of the incest (the father of the victim), and the mother of the victim, a factor analysis was carried out (Kerlinger, 1972). This was a principal components analysis with varimax rotation (Kaiser, 1958). Since the primary goal of the study was to differentiate attitudes toward the victim of incest from attitudes toward the perpetrator, the factor analysis was based entirely on ratings assigned in the incest vignette. In half of the cases the ratings assigned to the victim were employed, and in the other half the ratings assigned to the perpetrator were used. Each responding therapist was represented by a single set of ratings in the analysis, so as to preserve independence of observations (Heise, 1969).

The factor analysis of the 23 bipolar adjective pairs that responding therapists used to rate these two stimulus individuals yielded four clear conceptual dimensions. These were: (a) an evaluation factor, on which higher factor scores signified a more negative evaluation of the stimulus individual; (b) an attribution of blame factor, on which higher factor scores signified a perception of greater blame; (c) a psychosocial adjustment factor, on which higher factor scores signified a perception that the stimulus

individual was relatively well-adjusted; and (d) a potency factor, weighted such that higher numerical scores signified a perception of a relative lack of power or potency on the part of the stimulus individual.

The crucial aspect of the results of the factor analysis was the emergence of the attribution of blame factor. This factor was the second strongest among the four, and it provided a reliable measure of attribution of blame which could be employed in testing the three research hypotheses. Had no factor emerged representing attribution of blame, it would have been necessary to use ratings on one or more individual items to test the research hypotheses. In the rotated factor pattern matrix, the adjective pairs that had their highest loadings on the attribution of blame factor (see Table 2) were "innocent...guilty" (loading = .92), "blameless...blameworthy" (loading = .90), "responsible...not responsible" (loading = -.85), and "wrong...right" (loading = -.65). The high loadings of these items implied high internal consistency of the four items loading most heavily on the factor. Thus it was not surprising that the alpha coefficient calculated for the four-item cluster score was .95.

Mean Attribution of Blame Scores

Cluster scores were calculated for the attribution of blame, and descriptive statistics were obtained on these scores. The cluster scores have the advantage that they can be related directly to the paired-adjective response scale, thus providing an overall sense of the degree to which the therapists considered the victim to be guilty. Each of the four items had a seven-point response format. Thus the theoretical range of scores on the attribution of blame variable was from 4 to 28, with higher scores representing a greater

perception of blame. A score of 16 would correspond to the midpoint of the theoretical range, signifying a perception that the stimulus individual being rated was neither blameless nor blameworthy, but midway in between.

In this regard, it was noted that the mean attribution of blame score assigned to victims was less than 16 for both female and male therapists in their ratings of both female and male victims. In contrast, the corresponding mean attribution of blame scores that therapists assigned to the perpetrator, as well as those they assigned to the mother of the victim, were all above 16. Thus it may be concluded that the therapists in general did not tend to attribute very much blame to the victim, but did tend to attribute some blame to the victim's father (the perpetrator) and to the victim's mother. In the case of male therapists' ratings of the victim's father when the victim was a female, the mean attribution of blame score was 25.0 ($SD = 5.9$). This mean was close to the theoretical maximum score of 28.0. Thus the male therapists clearly saw a father who perpetrated incest on a daughter as highly blameworthy.

The question could be asked, "How many of the responding therapists attributed any blame whatsoever to the victim?" This question was difficult to answer in absolute terms, since scores on the attribution of blame to the victim of incest were continuous, ranging from 4 to 28. Thus every responding therapist has a score on attribution of blame to the victim, with some therapists simply having lower scores than others. With such a continuous variable, one would have to make some kind of subjective judgment regarding exactly what score constituted "no blame." One possibility that might make sense to some would be to count only the score of 4 as representing "no blame," since this would correspond to the lowest possible rating of blame (i.e., 1) on all four items

used in constructing the cluster score representing attribution of blame to the victim. The frequency distribution of cluster scores for attribution of blame to the victim indicated that there were 20 such respondents in the sample of 202.

Another possibility that might make sense to others would be to count any respondent with a score less than 16 as attributing no blame to the victim, since the score of 16 was the theoretical midpoint on the attribution of blame scale. A person assigning the victim a rating of four on each of four the adjective pairs that comprised the blame scale would be saying that the victim was midway between blameworthy and not blameworthy. There were 109 respondents who had scores on the attribution of blame cluster less than 16. These respondents could be said to have viewed the victim as relatively blameless.

The Effect of Therapist Gender on Attribution of Blame to the Victim

The first research hypothesis suggested that with respect to attribution of blame to the victim of incest, there would be a significant interaction between the gender of the responding therapist and the gender of the victim. Specifically, it was hypothesized that female therapists would tend to attribute relatively more blame to a male victim of incest than to a female victim, whereas male therapists would tend to attribute relatively more blame to a female victim than to a male victim. This hypothesis was based on findings reported by Josephson and Fong-Beyette (1987), who found that female victims of incest tended to perceive female counselors more favorably than male counselors. Several of the female victims in the Josephson and Fong-Beyette study indicated that they felt more comfortable disclosing the incest experience to a female counselor than to a male

counselor. It was reasoned that the perceptions of these counseling clients might be related to the degree of acceptance they experienced from their counselors, which in turn might be related to the extent to which the counselor blamed the victim for the incest.

The hypothesized interaction between the gender of the therapist and the gender of the victim was not supported by the data. No significant interactions were observed involving gender of therapist and gender of victim. The mean scores on attribution of blame assigned to the victim were higher for male victims than for female victims among both female therapists and male therapists. Among female therapists, the difference between mean attribution of blame scores for female victims ($M = 13.9$) and male victims ($M = 15.4$) was not significant. Among male therapists, the corresponding difference was significant ($M = 11.4$ for female victims; 15.5 for male victims). Thus the direction of difference was similar among female and male therapists; but the male therapists were somewhat less likely to assign blame to a female victim.

These findings may indicate that the comfort a victim experiences when discussing incest with a therapist may be determined by aspects of the interaction that are distinct from and independent of the therapist's attribution of blame to the victim. It is possible that male therapists might manifest greater discomfort than female therapists in discussing incest with a female victim, even though they do not blame the victim. This discomfort might reflect unconscious identification with a male perpetrator. This could cause a male therapist to avoid discussing the details of the sexual encounters or to minimize the importance of the effects of the incest. Either of these reactions could cause a female victim to feel uncomfortable in disclosing to a male therapist, in spite of the fact the therapist does not attribute blame to the victim. Of course, these possible

interpretations of the findings are highly speculative in nature, and further research will be required to understand the dynamics of the interactions between victims and opposite-sexed therapists. In addition, much more research is required relevant to male victims. At this point, however, it might be tentatively concluded that female victims of incest may experience greater comfort with female therapists than with male therapists, even though male therapists are not more likely than female therapists to attribute blame for incest to a female victim.

Therapist Background and Experience Factors

The second research hypothesis specified that the therapist's tendency to attribute blame to the victim of incest would be related negatively to the therapist's years of experience, prior experience working with victims of sexual abuse, exposure to preservice coursework on incest, level of education, and exposure to inservice training on incest. It was suggested that these relationships would pertain regardless of the gender of the therapist or the gender of the victim.

The findings of the study provided partial support for the hypothesis. As anticipated, the tendency to blame the victim was related negatively to the number of years of experience that the therapist reported, to the therapist's report of having actual experience working with victims of sexual abuse, and the exposure to preservice coursework on incest. Contrary to expectation, no significant relationships were observed between attribution of blame to the victim of incest and either highest degree or exposure to inservice training on incest.

The negative relationship observed between years of experience and the tendency to blame the therapist was quite strong ($r = .53, p = .000$). This suggests that several aspects of the therapist's experience may be contributing to the tendency not to blame the victim. One may speculate that more experienced therapists are simply better at making patients feel comfortable and accepted, and that this skill is matched by greater self-disclosure on the part of the patient. Such self-disclosure could result in the therapist having a more accurate and detailed sense of the nature of the sexual abuse, which in turn could minimize any tendency that the therapist might have to attribute blame to the victim. Alternatively or additionally, greater experience on the part of the therapist could simply result in greater knowledge of the typical course of incestuous relationships, which again might reduce the likelihood of attributing blame to the victim. The latter possibility was also consistent with the finding of a significant negative relationship between experience working with sexually abused patients and the tendency to attribute blame to the victim.

In any event, these findings may be viewed as suggesting the desirability of assigning patients who are suspected of having a history of incest to more experienced therapists and to therapists who have previous experience working with sexually abused clients. The findings may also be interpreted as indicating the desirability of therapists specializing in the treatment of sexually abused patients. Furthermore, the findings suggest the utility of preservice coursework on incest.

There are several possible explanations for the lack of any significant relationship between the tendency to attribute blame to the victim and the respondent's highest degree. It is possible that therapists with doctoral degrees are more likely to be working

anticipated that more empathic therapists would be relatively unlikely to blame the victim, as would therapists with more internal locus of control. The data supported the hypothesized relationship between empathy and attributions of blame toward the victim. Significant negative correlations were observed between attributions of blame toward the victim and three of the four empathy subscales of the Interpersonal Reactivity Index (Davis, 1980). These subscales were the Fantasy subscale, the Empathic Concern Subscale, and the Perspective Taking subscale. The IRI Fantasy subscale measured the respondent's tendency to identify with fictitious characters in novels, plays, and movies. Empathic concern was the tendency of the respondent to experience feelings of warmth, compassion, or concern for other individuals who are undergoing negative experiences. The personal distress subscale measured the likelihood that the respondent will experience feelings of anxiety and/or discomfort when witnessing the negative experiences of others. Therapists who scored high in each of these areas were less likely to attribute blame to the victim of incest than were therapists with low scores on these dimensions.

No relationship was observed between attribution of blame to the victim of incest and the fourth IRI subscale, perspective-taking. Perspective-taking referred to the ability of the respondent to adopt the perspective or point of view of other individuals. The lack of a significant relationship between empathic concern and attribution of blame to the victim of incest may possibly reflect the professional training and experience of the therapists. One expects that therapists will be used to adopting the perspectives of their clients, and that they will be rather good at it. This could imply some restriction of range on this variable within the sample, and restriction of range would reduce the likelihood of

obtaining a significant relationship between perspective-taking and attribution of blame. This possible explanation of the nonsignificant relationship was supported by the data in Table 9 (see page 90), which showed that the mean score on the IRI perspective-taking scale was the highest of any of the four IRI subscales, whereas the standard deviation of the perspective-taking subscale was the smallest of any of the four subscales.

The data did not support the hypothesized relationship between locus of control and attributions of blame to the victim of incest. There was no significant relationship between attributions of blame toward the victim and the responding therapists' scores on the Rotter Internal-External Locus of Control Scale (Rotter, 1966).

With respect to the observed negative relationships between therapist empathy and attributions of blame toward the victim, perhaps the most parsimonious explanation was that therapists who are better able to put themselves in the place of the victim would naturally be less likely to attribute any blame to that victim. A somewhat more complex but equally plausible argument has been offered by Davis (1980), who suggested that patients would feel more comfortable disclosing their incest experiences to a therapist whom they perceived as more empathic than to one they perceived as less empathic. But greater freedom to disclose on the part of the patient could make the therapist/patient relationship closer. It could also give the therapist a better idea of who the patient really is and what really happened. Either of these possibilities would be expected to reduce the likelihood that the therapist would blame the victim.

These findings suggested that preservice and inservice training experiences for clinicians who may be expected to deal with victims of sexual abuse should stress the importance of taking the perspective of the victim. Role playing exercises would appear

to be highly relevant in this regard. Of course, the use of therapists who had themselves experienced sexual abuse would be expected to foster the empathy of the therapist and to promote the development of a close bond between patient and therapist. For this reason, it would appear that the use of peer support interventions might also be beneficial to victims of sexual abuse.

The hypothesis that therapists with a strong internal locus of control would attribute less blame to the victim than therapists with a more external locus of control was based on the theory presented by Frenken and Van Stolk (1990). They argued that a therapist with a strong internal locus of control would not be threatened by the topic of incest and will therefore make greater efforts to elicit incest-related material from the client. In addition, it was anticipated that a therapist with a strong internal locus of control would be likely to convey a sense of self-confidence to the patient, and with it a belief that the therapeutic relationship has the potential to alleviate some of the patient's distress. This would also be expected to foster the patient's engagement in the therapeutic process.

The lack of a significant relationship between therapist locus of control and the therapist's attribution of blame to the victim suggested that other dynamics may be operating in the therapist/patient relationship. Perhaps a therapist with a more external locus of control was better able to identify with and have empathy for a victim of incest, who has been subjected to a situation where he or she has no control whatsoever over ongoing sexual abuse. This tendency would be consistent with the findings obtained with respect to therapist empathy, and it could offset any possible positive effects of therapist internal locus of control.

In this regard it was noteworthy that therapists with stronger internal control did tend to attribute greater blame to the perpetrator and to the victim's mother than did therapists with more external control. This could suggest that the therapists identified more closely with the adults involved in the incestuous situation than with the child who was the victim. If a therapist had a strong internal locus of control, he or she may believe that these adults should be in control of their feelings and actions, just as the therapist would be. Thus the therapist with a strong internal locus of control would not be likely to accept the argument that the perpetrator "couldn't help himself" or that the victim's mother was helpless to take action to prevent the abuse.

The significant positive relationships between therapist internal locus of control and attribution of blame to the perpetrator and to the victim's mother suggest that internal locus of control may be a desirable characteristic among clinicians treating victims of incest or other forms of sexual abuse. This would be the case not because these internally controlled therapists were either more or less likely to blame the victim, but rather because they may tend to have a more accurate perception of the appropriate targets for blame, the perpetrator and the potentially facilitating mother.

It was noteworthy, as well, that the literature indicated that victims of father-daughter incest often placed more blame on their mothers as on the fathers who actually abused them (Lusk & Waterman, 1986). This may reflect the accurate perception of the victim that their father was too seriously disturbed or too often too heavily inebriated to be held completely responsible for his actions. On the other hand, the victim may have perceived her mother as not too disturbed to know better. The victim may perceive the mother as ignoring the reprehensible behavior of her husband for selfish reasons. The

Vander Mey, B.J., & Neff, R. L. (1982). Adult-child incest: A review of research and treatment. *Adolescence, 17*, 717-735.

Waller, G. (1992). Sexual abuse and bulimic symptoms in eating disorders: Do family interaction and self-esteem explain the links? *International Journal of Eating Disorders, 12*, 235-240.

Ware, R.C. (1995). Scylla and Charybdis: Sexual abuse or "false memory syndrome?" *Journal of Analytical Psychology, 40* (1), 5-22.

Weinberg, K. (1955). *Incest behavior*. New York: Citadel Press.

Weiner, I. (1962). Father-daughter incest. *Psychiatric Quarterly, 36*, 607-632.

Weiss, J., Rogers, E., Darwin, M.R., & Dutton, D. E. (1955). A study of girl sex victims. *Psychiatric Quarterly, 29*, 1-26.

Westermeyer, J. (1978). *Incest in psychiatric practice: A description of patients and incestuous relationships*. New York: Basic Books.

Wilbur, C. B. (1984). Multiple personality and child abuse. *Psychiatric Clinics of North America, 7*, 3-8.

Wyatt, G.E. (1985). The sexual abuse of Afro-American and White American women in childhood. *Child Abuse and Neglect, 9*, 507-519.

Wyatt, G.E., & Peters, S.D. (1986). Issues in the definition of child sexual abuse in prevalence research. *Child Abuse and Neglect, 10*, 231-240.

Yates, A. (1982). Children eroticized by incest. *American Journal of Psychiatry, 139*, 482-485.

Yorukoglu, A., & Kemph, G. (1966). Children not severely damaged by incest with a parent. *Journal of the American Academy of Child Psychiatry, 5,* 111-124.

Zanarini, M. C. (Ed.) (1997). *The role of sexual abuse in the etiology of borderline personality disorder.* Washington, DC: American Psychiatric Press.

Zanarini, M. C., Dubo, E. D., Lewis, R. E., & Williams, A. A. (1997). Childhood factors associated with the development of borderline personality disorder. In M.C. Zanarini (Ed.), *The role of sexual abuse in the etiology of borderline personality disorder* (pp. 29-44). Washington, DC: American Psychiatric Press.

Zanarini, M. C., Gunderson, J. G., & Frankenburg, F. R. (1989). The Revised Diagnostic Interview for Borderlines: Discriminating BPD from other Axis II disorders. *Journal of Personality Disorders, 3,* 10-18.

Zanarini, M.C., Gunderson, J.G., & Marino, C. (1989). Childhood experiences of borderline patients. *Comparative Psychiatry, 28,* 467-480.

Zeitlin, S.B., McNally, R.J. & Cassiday, K.L. (1993). Alexithymia in victims of sexual assault: An effect of repeated traumatization? *American Journal of Psychiatry, 150* (4), 661-663.

Zerbe, K.J. (1992). Eating disorders in the 1990s: Clinical challenges and treatment implications. *Bulletin of the Menninger Clinic, 56,* 167-187.

Appendix A
Letter of Solicitation and
Survey Instrument

Dear Colleague:

My name is Marie Geron, and I am a doctoral student currently involved in research for my dissertation, which is concerned with childhood trauma. There appears to be a lack of empirical research relevant to therapists' perceptions of traumatic experiences in childhood and serious childhood disorders. I would greatly appreciate it if you could take a few minutes of your time to complete a survey questionnaire concerned with some of these issues.

The study involves reading four vignettes that describe four different problems that may be experienced in childhood or adolescence. After you read each vignette, you will be asked to rate several family members on a series of 20 paired adjective scales. In addition, you will be asked to complete a survey questionnaire that includes a measure of interpersonal reactivity, The Interpersonal Reactivity Index, a locus of control scale, The Rotter Internal-External Locus of Control Scale, and a demographic and background questionnaire.

I realize that your time is valuable, and I also believe that it is important to gain greater understanding of traumatic experiences in childhood and serious childhood disorders. I am using several several different scales in the questionnaire, because I want to take a more in-depth, rather than a superficial, look at aspects of traumatic experiences in childhood and serious childhood disorders.

This study is being carried out in partial fulfillment of the requirements for my doctoral degree. It is hoped that the study will yield information helpful to clinicians in their work with childhood disorders. We hope to draw upon your expertise to complete this important research. Completion of the survey should require no more than about 30 minutes.

Your responses to the survey questionnaire will be completely confidential and anonymous. Do not indicate your name or any other identifying data on the survey instrument itself. If you decide to take part, please sign the informed consent statement contained at the end of this letter and return it in to me separately from the survey itself. By returning the consent form separately, the anonymity of your responses will be guaranteed.

If you choose to participate, your participation remains voluntary throughout the project. If you should decide to discontinue, you can simply stop answering the materials and discard them. If you feel that you would become too uncomfortable completing the survey, please feel free not to participate. The questions in the survey may be helpful in thinking about some of your experiences. For some people, answering some of the questions may stir up some uncomfortable feelings. If this happens to you, I encourage you to talk them over with someone who can be helpful to you-- your partner, a friend, or a professional therapist or counselor.

After the results are analyzed, I will be glad to make a copy of the group findings available to you with an explanation of what the various parts

of the survey instrument measure. In order to keep your identity confidential and separate from your survey questionnaire, you can write me at the address on the bottom of this page and ask for a copy of the results.

This project has been reviewed and approved by the Seton Hall University Institutional Review Board for Human Subjects Research. The IRB believes that the research procedures adequately safeguard the subjects' privacy, welfare, civil liberties, and rights. The chairperson of the IRB may be reached through the Office of Grants and Research Services. The telephone number of the office is (973)-275-2974.

Thank you very much for your valuable assistance in this important research project.

Sincerely,

Marie Geron
53 Lenox Road
Summit, N.J. 07901

Consent Form:

I have read the material above, and any questions I asked have been answered to my satisfaction. I agree to participate in this activity, realizing that I may withdraw without prejudice at any time.

_____ _____

subject or authorized representative date

PART ONE

The first section of the survey contains vignettes describing four different situations that can affect children or adolescents. The vignettes contain intake information about four families, because we would like to get your professional judgment with regard to these families.

Please read each of the case descriptions carefully. After reading each vignette, you will be asked to make some judgments about the family members described in the vignette. You will do this by evaluating the family members on a series of paired-opposite adjective pairs. For example, you will see the adjectives sociable and unsociable on opposite sides of the page, separated by seven dashes:

sociable ___ ___ ___ ___ ___ ___ ___ unsociable

In response to this item, you would place a check on the line closest to "sociable" if you thought the person in question was very sociable. You would place a check on the line closest to "unsociable" if you thought the person in question was very unsociable. You would check the middle (fourth) dash if you thought the person was no more sociable than unsociable. The other dashes can be used to indicate that the person in question is more like one adjective than the other, but not totally like that adjective.

The vignettes follow:

Vignette One

Susan (Josh) is an attractive 14 year-old girl (boy) who has just entered treatment after disclosing that she (he) has been involved in a sexual relationship with her (his) father for nearly two years. The incest began shortly after Susan (Josh) reached puberty. The relationship involved many instances of both oral sex and genital (anal) intercourse.

Susan's (Josh's) father is reported to be an alcoholic, and the sex acts typically occurred at times when he was intoxicated. Susan's (Josh's) mother first indicated that she did not know about the incest until Susan (Josh) disclosed it to her recently. However, she later acknowledged that she had been "suspicious" for several months.

Susan (Josh) has been placed in a foster care situation with his maternal grandparents, and she has begun individual psychotherapy.

(1) Please rate Susan (Josh) on the following paired opposite adjectives:

sociable ___ ___ ___ ___ ___ ___ ___
unsociable

large ___ ___ ___ ___ ___ ___ ___ small
clean ___ ___ ___ ___ ___ ___ ___ dirty
healthy ___ ___ ___ ___ ___ ___ ___ sick
good ___ ___ ___ ___ ___ ___ ___ bad
sad ___ ___ ___ ___ ___ ___ ___ happy
weak ___ ___ ___ ___ ___ ___ ___ strong
honest ___ ___ ___ ___ ___ ___ ___
dishonest

delicate ___ ___ ___ ___ ___ ___ ___ rugged
beautiful ___ ___ ___ ___ ___ ___ ___ ugly
blameless ___ ___ ___ ___ ___ ___ ___ blameworthy
tense ___ ___ ___ ___ ___ ___ ___ relaxed
loud ___ ___ ___ ___ ___ ___ ___ quiet
intact ___ ___ ___ ___ ___ ___ ___
damaged

anxious ___ ___ ___ ___ ___ ___ ___ calm
innocent ___ ___ ___ ___ ___ ___ ___ guilty
isolated ___ ___ ___ ___ ___ ___ ___
connected

wrong ___ ___ ___ ___ ___ ___ ___ right
responsible ___ ___ ___ ___ ___ ___ ___ not responsible
fast ___ ___ ___ ___ ___ ___ ___ slow
controlling ___ ___ ___ ___ ___ ___ ___
controlled

active ___ ___ ___ ___ ___ ___ ___ passive
damaged ___ ___ ___ ___ ___ ___ ___ intact

(2) Now, would you please rate Susan's (Josh's) father on the same adjective pairs:

sociable ___ ___ ___ ___ ___ ___ ___ unsociable
large ___ ___ ___ ___ ___ ___ ___ small
clean ___ ___ ___ ___ ___ ___ ___ dirty
healthy ___ ___ ___ ___ ___ ___ ___ sick
good ___ ___ ___ ___ ___ ___ ___ bad
sad ___ ___ ___ ___ ___ ___ ___ happy
weak ___ ___ ___ ___ ___ ___ ___ strong
honest ___ ___ ___ ___ ___ ___ ___ dishonest
delicate ___ ___ ___ ___ ___ ___ ___ rugged
beautiful ___ ___ ___ ___ ___ ___ ___ ugly

blameless	___	___	___	___	___	___	___ blameworthy
tense	___	___	___	___	___	___	___ relaxed
loud	___	___	___	___	___	___	___ quiet
intact	___	___	___	___	___	___	___ damaged
anxious	___	___	___	___	___	___	___ calm
innocent	___	___	___	___	___	___	___ guilty
isolated	___	___	___	___	___	___	___ connected
wrong	___	___	___	___	___	___	___ right
responsible	___	___	___	___	___	___	___ not responsible
fast	___	___	___	___	___	___	___ slow
controlling	___	___	___	___	___	___	___ controlled
active	___	___	___	___	___	___	___ passive
damaged	___	___	___	___	___	___	___ intact

(3) And now please rate Susan's (Josh's) mother on the same adjective pairs:

sociable	___	___	___	___	___	___	___ unsociable
large	___	___	___	___	___	___	___ small
clean	___	___	___	___	___	___	___ dirty
healthy	___	___	___	___	___	___	___ sick
good	___	___	___	___	___	___	___ bad
sad	___	___	___	___	___	___	___ happy
weak	___	___	___	___	___	___	___ strong
honest	___	___	___	___	___	___	___ dishonest
delicate	___	___	___	___	___	___	___ rugged
beautiful	___	___	___	___	___	___	___ ugly
blameless	___	___	___	___	___	___	___ blameworthy
tense	___	___	___	___	___	___	___ relaxed
loud	___	___	___	___	___	___	___ quiet
intact	___	___	___	___	___	___	___ damaged
anxious	___	___	___	___	___	___	___ calm
innocent	___	___	___	___	___	___	___ guilty
isolated	___	___	___	___	___	___	___ connected
wrong	___	___	___	___	___	___	___ right
responsible	___	___	___	___	___	___	___ not responsible
fast	___	___	___	___	___	___	___ slow
controlling	___	___	___	___	___	___	___ controlled
active	___	___	___	___	___	___	___ passive
damaged	___	___	___	___	___	___	___ intact

Now, please read this second case description, and respond as directed below:

Vignette Two

Anne (Chuck) is an attractive 14 year-old girl (boy) who has just disclosed that she (he) had been beaten repeatedly over the past two years by her (his) father. Anne (Chuck) explained that her (his) father has a terrible temper, especially after he has been drinking.

The physical abuse consisted of being slapped and being struck with the fists. The injuries Anne (Chuck) sustained included bruises and black eyes, and she (he) indicated that on a number of occasions these injuries were serious enough to be embarrassing and to keep her (him) from going to school.

Following her disclosure, Anne's (Chuck's) father was ordered out of the house by child protective services officals. In addition, Anne (Chuck) began group and individual psychotherapy

(1) Please rate Anne (Chuck) on the following paired opposite adjectives:

	sociable	___	___	___	___	___	___	___	
unsociable									
	large	___	___	___	___	___	___	___	small
	clean	___	___	___	___	___	___	___	dirty
	healthy	___	___	___	___	___	___	___	sick
	good	___	___	___	___	___	___	___	bad
	sad	___	___	___	___	___	___	___	happy
	weak	___	___	___	___	___	___	___	strong
	honest	___	___	___	___	___	___	___	
dishonest									
	delicate	___	___	___	___	___	___	___	rugged
	beautiful	___	___	___	___	___	___	___	ugly
	blameless	___	___	___	___	___	___	___	blameworthy
	tense	___	___	___	___	___	___	___	relaxed
	loud	___	___	___	___	___	___	___	quiet
	intact	___	___	___	___	___	___	___	damaged
	anxious	___	___	___	___	___	___	___	calm

innocent ___ ___ ___ ___ ___ ___ ___ guilty
isolated ___ ___ ___ ___ ___ ___ ___ connected
wrong ___ ___ ___ ___ ___ ___ ___ right
responsible___ ___ ___ ___ ___ ___ ___ not responsible
fast ___ ___ ___ ___ ___ ___ ___ slow
controlling___ ___ ___ ___ ___ ___ ___ controlled
active ___ ___ ___ ___ ___ ___ ___ passive
damaged ___ ___ ___ ___ ___ ___ ___ intact

(2) Now, please rate Anne's (Chuck's) father on the same adjective pairs:

sociable ___ ___ ___ ___ ___ ___ ___ unsociable
large ___ ___ ___ ___ ___ ___ ___ small
clean ___ ___ ___ ___ ___ ___ ___ dirty
healthy ___ ___ ___ ___ ___ ___ ___ sick
good ___ ___ ___ ___ ___ ___ ___ bad
sad ___ ___ ___ ___ ___ ___ ___ happy
weak ___ ___ ___ ___ ___ ___ ___ strong
honest ___ ___ ___ ___ ___ ___ ___ dishonest
delicate ___ ___ ___ ___ ___ ___ ___ rugged
beautiful ___ ___ ___ ___ ___ ___ ___ ugly
blameless ___ ___ ___ ___ ___ ___ ___ blameworthy
tense ___ ___ ___ ___ ___ ___ ___ relaxed
loud ___ ___ ___ ___ ___ ___ ___ quiet
intact ___ ___ ___ ___ ___ ___ ___ damaged
anxious ___ ___ ___ ___ ___ ___ ___ calm
innocent ___ ___ ___ ___ ___ ___ ___ guilty
isolated ___ ___ ___ ___ ___ ___ ___ connected
wrong ___ ___ ___ ___ ___ ___ ___ right
responsible___ ___ ___ ___ ___ ___ ___ not responsible
fast ___ ___ ___ ___ ___ ___ ___ slow
controlling___ ___ ___ ___ ___ ___ ___ controlled
active ___ ___ ___ ___ ___ ___ ___ passive
damaged ___ ___ ___ ___ ___ ___ ___ intact

(3) And now please rate Anne's (Chuck's) mother on the same adjective pairs:

sociable ___ ___ ___ ___ ___ ___ ___ unsociable
large ___ ___ ___ ___ ___ ___ ___ small
clean ___ ___ ___ ___ ___ ___ ___ dirty

healthy	___	___	___	___	___	___	___	sick
good	___	___	___	___	___	___	___	bad
sad	___	___	___	___	___	___	___	happy
weak	___	___	___	___	___	___	___	strong
honest	___	___	___	___	___	___	___	dishonest
delicate	___	___	___	___	___	___	___	rugged
beautiful	___	___	___	___	___	___	___	ugly
blameless	___	___	___	___	___	___	___	blameworthy
tense	___	___	___	___	___	___	___	relaxed
loud	___	___	___	___	___	___	___	quiet
intact	___	___	___	___	___	___	___	damaged
anxious	___	___	___	___	___	___	___	calm
innocent	___	___	___	___	___	___	___	guilty
isolated	___	___	___	___	___	___	___	connected
wrong	___	___	___	___	___	___	___	right
responsible	___	___	___	___	___	___	___	not responsible
fast	___	___	___	___	___	___	___	slow
controlling	___	___	___	___	___	___	___	controlled
active	___	___	___	___	___	___	___	passive
damaged	___	___	___	___	___	___	___	intact

Now, please read this third case description, and respond as directed below:

Vignette Three

Sam (Jenny) is an energetic fourteen year-old who has been retained in grade twice due to poor achievement in reading and mathematics. He (she) is currently in eighth grade. Sam (Jenny) has always had a great deal of difficulty in paying attention to his (her) school work. He (she) has frequently exhibited impulsive behavior in the classroom, leaving his (her) seat, and speaking spontaneously at inappropriate times, making it difficult for the other students to work.

The father, who uses considerable caffeine and nicotine to keep himself moving at the hectic pace required by his very demanding work, feels that the child could control his (her) behavior if only he (she) would "grow up" and "get serious." He punishes low performance on tests and poor report cards by grounding the child to his (her) room and assigning enforced study hours.

(1) Please rate Sam (Jenny) on each of the following paired opposite adjective pairs:

sociable	___	___	___	___	___	___	___	unsociable
large	___	___	___	___	___	___	___	small
clean	___	___	___	___	___	___	___	dirty
healthy	___	___	___	___	___	___	___	sick
good	___	___	___	___	___	___	___	bad
sad	___	___	___	___	___	___	___	happy
weak	___	___	___	___	___	___	___	strong
honest	___	___	___	___	___	___	___	dishonest
delicate	___	___	___	___	___	___	___	rugged
beautiful	___	___	___	___	___	___	___	ugly
blameless	___	___	___	___	___	___	___	blameworthy
tense	___	___	___	___	___	___	___	relaxed
loud	___	___	___	___	___	___	___	quiet
intact	___	___	___	___	___	___	___	damaged
anxious	___	___	___	___	___	___	___	calm
innocent	___	___	___	___	___	___	___	guilty
isolated	___	___	___	___	___	___	___	connected
wrong	___	___	___	___	___	___	___	right
responsible	___	___	___	___	___	___	___	not responsible
fast	___	___	___	___	___	___	___	slow
controlling	___	___	___	___	___	___	___	controlled
active	___	___	___	___	___	___	___	passive
damaged	___	___	___	___	___	___	___	intact

(2) Now, please rate Sam's (Jenny's) father on the same adjective pairs:

sociable	___	___	___	___	___	___	___	unsociable
large	___	___	___	___	___	___	___	small
clean	___	___	___	___	___	___	___	dirty
healthy	___	___	___	___	___	___	___	sick
good	___	___	___	___	___	___	___	bad
sad	___	___	___	___	___	___	___	happy
weak	___	___	___	___	___	___	___	strong
honest	___	___	___	___	___	___	___	dishonest
delicate	___	___	___	___	___	___	___	rugged
beautiful	___	___	___	___	___	___	___	ugly
blameless	___	___	___	___	___	___	___	blameworthy
tense	___	___	___	___	___	___	___	relaxed
loud	___	___	___	___	___	___	___	quiet
intact	___	___	___	___	___	___	___	damaged
anxious	___	___	___	___	___	___	___	calm
innocent	___	___	___	___	___	___	___	guilty
isolated	___	___	___	___	___	___	___	connected
wrong	___	___	___	___	___	___	___	right

responsible ___ ___ ___ ___ ___ ___ ___ not responsible
fast ___ ___ ___ ___ ___ ___ ___ slow
controlling ___ ___ ___ ___ ___ ___ ___ controlled
active ___ ___ ___ ___ ___ ___ ___ passive
damaged ___ ___ ___ ___ ___ ___ ___ intact

(3) And now please rate Sam's (Jenny's) mother on the same adjective pairs:

sociable ___ ___ ___ ___ ___ ___ ___ unsociable
large ___ ___ ___ ___ ___ ___ ___ small
clean ___ ___ ___ ___ ___ ___ ___ dirty
healthy ___ ___ ___ ___ ___ ___ ___ sick
good ___ ___ ___ ___ ___ ___ ___ bad
sad ___ ___ ___ ___ ___ ___ ___ happy
weak ___ ___ ___ ___ ___ ___ ___ strong
honest ___ ___ ___ ___ ___ ___ ___ dishonest
delicate ___ ___ ___ ___ ___ ___ ___ rugged
beautiful ___ ___ ___ ___ ___ ___ ___ ugly
blameless ___ ___ ___ ___ ___ ___ ___ blameworthy
tense ___ ___ ___ ___ ___ ___ ___ relaxed
loud ___ ___ ___ ___ ___ ___ ___ quiet
intact ___ ___ ___ ___ ___ ___ ___ damaged
anxious ___ ___ ___ ___ ___ ___ ___ calm
innocent ___ ___ ___ ___ ___ ___ ___ guilty
isolated ___ ___ ___ ___ ___ ___ ___ connected
wrong ___ ___ ___ ___ ___ ___ ___ right
responsible ___ ___ ___ ___ ___ ___ ___ not responsible
fast ___ ___ ___ ___ ___ ___ ___ slow
controlling ___ ___ ___ ___ ___ ___ ___ controlled
active ___ ___ ___ ___ ___ ___ ___ passive
damaged ___ ___ ___ ___ ___ ___ ___ intact

Now, please read this fourth case description, and respond as directed below:

Vignette Four

Brian (Jane) is a precocious 14 year-old high school student. Until the last few months, he (she) was a popular student-athlete, and he (she) was accepted as an early admission applicant at a prestigious university. A few months ago, however, Brian (Jane) began to spend more and more time by him (her) self in his (her) room. He (she) said that he (she) felt uncomfortable around his friends, because they were all jealous of him (her) and they were plotting against him (her). Brian (Jane) is withdrawing from school activities and is now heavily involved in reading about astrology, UFOs, and the occult. Most recently, the teen has complained of hearing voices that are not heard by other family members, and he (she) has been using alcohol to help quiet these voices down.

The teen spends most of the day in the house, rarely gets fully dressed and has become increasingly disorganized and unkempt. A psychiatrist, seen at the request of the school psychologist, recently made the diagnosis of schizophenia and prescribed medication in an effort to control the symptoms of psychosis.

The father, a worrier who is overburdened with fears of being downsized from his company and faces the prospect of not meeting his financial obligations, refuses to "give in" to this definition of his son/daughter's problems and alternates between cajoling and demanding that the child "snap out of it" and get back into the swing of social activities and studies.

(1) Please rate Brian (Jane) on these adjective pairs:

sociable	___	___	___	___	___	___	___ unsociable
large	___	___	___	___	___	___	___ small
clean	___	___	___	___	___	___	___ dirty
healthy	___	___	___	___	___	___	___ sick
good	___	___	___	___	___	___	___ bad
sad	___	___	___	___	___	___	___ happy
weak	___	___	___	___	___	___	___ strong
honest	___	___	___	___	___	___	___ dishonest
delicate	___	___	___	___	___	___	___ rugged
beautiful	___	___	___	___	___	___	___ ugly
blameless	___	___	___	___	___	___	___ blameworthy
tense	___	___	___	___	___	___	___ relaxed
loud	___	___	___	___	___	___	___ quiet
intact	___	___	___	___	___	___	___ damaged
anxious	___	___	___	___	___	___	___ calm
innocent	___	___	___	___	___	___	___ guilty
isolated	___	___	___	___	___	___	___ connected

wrong	___	___	___	___	___	___	___	right
responsible	___	___	___	___	___	___	___	not responsible
fast	___	___	___	___	___	___	___	slow
controlling	___	___	___	___	___	___	___	controlled
active	___	___	___	___	___	___	___	passive
damaged	___	___	___	___	___	___	___	intact

(2) Now please rate Brian's (father) on these same adjective pairs:

sociable	___	___	___	___	___	___	___	unsociable
large	___	___	___	___	___	___	___	small
clean	___	___	___	___	___	___	___	dirty
healthy	___	___	___	___	___	___	___	sick
good	___	___	___	___	___	___	___	bad
sad	___	___	___	___	___	___	___	happy
weak	___	___	___	___	___	___	___	strong
honest	___	___	___	___	___	___	___	dishonest
delicate	___	___	___	___	___	___	___	rugged
beautiful	___	___	___	___	___	___	___	ugly
blameless	___	___	___	___	___	___	___	blameworthy
tense	___	___	___	___	___	___	___	relaxed
loud	___	___	___	___	___	___	___	quiet
intact	___	___	___	___	___	___	___	damaged
anxious	___	___	___	___	___	___	___	calm
innocent	___	___	___	___	___	___	___	guilty
isolated	___	___	___	___	___	___	___	connected
wrong	___	___	___	___	___	___	___	right
responsible	___	___	___	___	___	___	___	not responsible
fast	___	___	___	___	___	___	___	slow
controlling	___	___	___	___	___	___	___	controlled
active	___	___	___	___	___	___	___	passive
damaged	___	___	___	___	___	___	___	intact

(3) Finally, please rate Brian's (Jane's) mother on the same adjective pairs:

sociable	___	___	___	___	___	___	___	unsociable
large	___	___	___	___	___	___	___	small
clean	___	___	___	___	___	___	___	dirty
healthy	___	___	___	___	___	___	___	sick
good	___	___	___	___	___	___	___	bad
sad	___	___	___	___	___	___	___	happy
weak	___	___	___	___	___	___	___	strong
honest	___	___	___	___	___	___	___	dishonest

delicate	___	___	___	___	___	___	___	rugged
beautiful	___	___	___	___	___	___	___	ugly
blameless	___	___	___	___	___	___	___	blameworthy
tense	___	___	___	___	___	___	___	relaxed
loud	___	___	___	___	___	___	___	quiet
intact	___	___	___	___	___	___	___	damaged
anxious	___	___	___	___	___	___	___	calm
innocent	___	___	___	___	___	___	___	guilty
isolated	___	___	___	___	___	___	___	connected
wrong	___	___	___	___	___	___	___	right
responsible	___	___	___	___	___	___	___	not responsible
fast	___	___	___	___	___	___	___	slow
controlling	___	___	___	___	___	___	___	controlled
active	___	___	___	___	___	___	___	passive
damaged	___	___	___	___	___	___	___	intact

PART TWO:

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well the statement describes you by choosing the appropriate number on the scale at the top of the page. Read each item carefully before responding. Answer as honestly as you can. Thank you.

1	2	3	4	5
not at all like me		somewhat like me		very much like me

item	response (1 to 5)
1 I daydream and fantacize, with some regularity, about that might happen to me.	____
2 I often have tender, concerned feelings for people less fortunate than me.	____
3 I sometimes find it difficult to see things from the "other guy's" point of view	____
4 Sometimes I don't feel very sorry for other people when they are having problems	____
5 I really get involved with the feelings of the characters in a novel	____
6 In emergency situations, I feel apprehensive and ill-at-ease.	____
7 I am usually objective when I watch a movie or play, and I don't often get completely caught up in it	____
8. I try to look at everybody's side of a disagreement before I make a decision	____
9. When I see someone being taken advantage of, I feel kind protective toward them.	____
10. I sometimes feel helpless when I am in the middle of a very emotional situation.	____

11. I sometimes try to understand my friends better by imagining how things look from their perspective. ____

12. Becoming extremely involved in a good book or movie is somewhat rare for me. ____

13. When I see someone get hurt, I remain calm. ____

14. Other people's misfortunes do not usually disturb me a great deal ____

15. If I'm sure that I'm right about something, I don't waste much time listening to other people's arguments ____

16. After seeing a play or movie, I have felt as though I were one of the characters. ____

17. Being in tense emotional situations scares me. ____

18. When I see someone being treated unfairly, I sometimes don't feel very much pity for them. ____

19. I am usually pretty effective in dealing with emergencies. ____

20. I am often quite touched by things that I see happen. ____

21. I believe that there are two sides to every question and try to look at them both. ____

22. I would describe myself as a pretty soft-hearted person ____

23. When I watch a good movie, I can easily put myself in the place of the leading character ____

24. I tend to lose control during emergencies. ____

25. When I'm upset at someone, I usually try to "put myself in his shoes" for a while. ____

26. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me. ____

27. When I see someone who badly needs help in an emergency, I go to pieces. ____

28. Before criticizing somebody, I try to imagine how I would feel if I were in their place. ____

PART THREE:

The items below each consist of two sentences, labeled (a) and (b). Please read each pair of sentences and circle the letter of the sentence with which you agree the most. Please circle one and only one sentence in each pair.

1. a. Children get into trouble because their parents punish them too much.

   b. The trouble with most children nowadays is that their parents are too easy with them.

2. a. Many of the unhappy things in people's lives are partly due to bad luck.

   b. People's misfortunes result from the mistakes they make.

3. a. One of the major reasons why we have wars is because people don't take enough interest in politics.

   b. There will always be wars, no matter how hard people try to prevent them.

4. a. In the long run people get the respect they deserve in this world.

   b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. a. The idea that teachers are unfair to students is nonsense.

   b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6. a. Without the right breaks one cannot be an effective leader.

   b. Capable people who fail to become leaders have not taken advantage of their opportunities.

victim may also feel that by not acting to protect her, her mother has betrayed a fundamental bond between parent and child, the bond forged by the protection from danger provided by the parent.

Implications

The findings of the present study suggested that victims of incest may well have more positive experiences in therapy to the extent that their therapists are more experienced in general, more experienced working with victims of sexual abuse, and better trained in preservice coursework on incest. The findings also suggested that victims of incest may feel better about being in treatment with therapists who manifest high levels of empathy in the form of the capacity to experience themselves in the position of the victim and view the incestuous situation through his or her eyes. Finally, the findings suggested the possibility that therapists with strong internal control may view incest more clearly than those with more external control, in that they are more willing to assign blame to the adults, figures who should be responsible for the welfare of the child.

These findings were hardly surprising, yet in the context of the prevalence of incest in our society, the negative psychosocial outcomes that characterize incest victims, and the widespread dissatisfaction with therapy on the part of incest victims, the findings were extremely important. It goes without saying that a victim will make little progress in treatment if he or she feels uncomfortable discussing the incestuous experience and the meanings of that experience.

In this context, it is worth emphasizing that a therapist may discourage self-disclosure by means of a number of behaviors that are not necessarily obvious. Of course

In this regard it was noteworthy that therapists with stronger internal control did tend to attribute greater blame to the perpetrator and to the victim's mother than did therapists with more external control. This could suggest that the therapists identified more closely with the adults involved in the incestuous situation than with the child who was the victim. If a therapist had a strong internal locus of control, he or she may believe that these adults should be in control of their feelings and actions, just as the therapist would be. Thus the therapist with a strong internal locus of control would not be likely to accept the argument that the perpetrator "couldn't help himself" or that the victim's mother was helpless to take action to prevent the abuse.

The significant positive relationships between therapist internal locus of control and attribution of blame to the perpetrator and to the victim's mother suggest that internal locus of control may be a desirable characteristic among clinicians treating victims of incest or other forms of sexual abuse. This would be the case not because these internally controlled therapists were either more or less likely to blame the victim, but rather because they may tend to have a more accurate perception of the appropriate targets for blame, the perpetrator and the potentially facilitating mother.

It was noteworthy, as well, that the literature indicated that victims of father-daughter incest often placed more blame on their mothers as on the fathers who actually abused them (Lusk & Waterman, 1986). This may reflect the accurate perception of the victim that their father was too seriously disturbed or too often too heavily inebriated to be held completely responsible for his actions. On the other hand, the victim may have perceived her mother as not too disturbed to know better. The victim may perceive the mother as ignoring the reprehensible behavior of her husband for selfish reasons. The

the therapist who overtly blames the victim or questions the reality or extensiveness of the abuse will cause the victim to withdraw, but the therapist may also discourage patient self-disclosure by simply failing to follow-up on veiled allusions to abuse or by unconsciously indicating discomfort when the patient brings up the topic. Therefore it is important that therapists be trained to be aware of these possibilities both through academic study of the theoretical and research literature, and through clinical training in supervised practicum and internship experiences. Specifically it would appear to be important for therapists to hone their capacity for empathic response and their sensitivity toward subtle cues indicating childhood abuse. It is also desirable that experienced clinicians continue to receive supervision for cases involving sensitive topics such as incest or other forms of sexual abuse.

In particular, therapists should receive training aimed at helping them to recognize unpleasant feelings that they may have which might lead them to turn the discussion in therapy away from the possibility of incest in the family to less disturbing subjects. Supervision is frequently aimed at helping therapists recognize negative feelings that arise and identify the sources of such feelings. Such training can help therapists to overcome unconscious aversions and facilitate the discussion of issues which, though unpleasant, are nevertheless crucial to the treatment process.

Therapists would also benefit from training aimed at assisting them to understand the negative reactions of victims to their mothers, whom they may blame for not interceding to protect them. Therapists should learn to regard, with caution, tendencies of victims of incest to overidealize the nonoffending parent, as such perceptions may in fact

represent defense mechanisms aimed at preventing the emergence of feelings of anger which need to be expressed and worked through.

Recommendations for Future Research

The research reported here was based on the responses of therapists to a survey questionnaire. While care was taken to use nonreactive measures so as to insure accurate assessment of therapist attitudes, the results still reflect only the perceptions of therapists. Further research is required to determine the relationships between therapist attitudes and the perceptions and behaviors of their patients. In addition, future studies should include measurable patient outcome variables, including measures of short and long-term psychosocial adjustment. Such studies are considerably broader in scope than the study reported here, since these studies will involve the use of patient/therapist dyads. In addition, these studies would ideally have a longitudinal component, assessing not only the patients' immediate experiences of the therapeutic relationship, but the long-term outcomes of their treatment.

Much of the existing research involving patients' perceptions has focused on their satisfaction with their therapists (Frenken & Van Stolk, 1990). But satisfaction is not really an outcome variable, although it may well be related to outcomes. Future studies should investigate the relationship between patient satisfaction and retention in treatment, as well as the relationship between patient satisfaction with treatment and subsequent psychosocial outcomes.

It also appears that qualitative research based on in-depth interviews with patients and therapists would provide valuable insights into the process of treatment of victims of

incest, including the characteristics of therapists and the aspects of treatment that patients experience as most helpful. Ideally such a qualitative component would be included along with a quantitative study involving both therapist and patient reports. In this way the participants' perceptions of the process could be discussed in the context of the findings based on measured outcome criteria.

References

Aarens, M., Camern, T., & Roizen, J. (1978). *Alcohol, casualties, and crime.* Berkeley, CA: Social Research Group.

Adams, C.B.L. (1996). Treatment and prevention of child sexual abuse. In S.J. Kaplan, (Ed.), *Family violence: A clinical and legal guide* (pp.105-138). Washington, DC: American Psychiatric Press.

Adams-Tucker, C. (1981). A socioclinical overview of 28 sex-abused children. *Child Abuse and Neglect, 5,* 361-367.

Adams-Tucker, C. (1982). Proximate effects of sexual abuse in childhood: A report on 28 children. *American Journal of Psychiatry, 139,* 1252-1256.

Alpert, J.L., Brown, L.S., Ceci, S.J., Courtois, C.A., Loftus, E.F., & Ornstein, P.A. (1995). *Working group on investigation of memories of childhood abuse: Final report.* Washington, DC: American Psychological Association.

American Psychiatric Association (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.

Bagley, C., & Ramsey, R. L. (1986). Sexual abuse in childhood: Psychosocial outcomes and implications for social work practice. *Journal of Social Work and Human Sexuality, 4*, 33-47.

Bender, L., & Grugett, A.E. (1952). Follow-up report on children who had atypical sex experience. *American Journal of Orthopsychiatry, 22*, 825-837.

Bess, B.E., & Janssen, Y. (1982). Incest: A pilot study. *Hillside Journal of Clinical Psychiatry, 4*, 39-52.

Blumberg, M. L. (1978). Child sexual abuse: Ultimate in maltreatment syndrome. *New York State Journal of Medicine, 78*, 612-616.

Blumberg, M.L. (1981). Depression in abused and neglected children. *American Journal of Psychotherapy, 35*, 342-355.

Boatman, B., Borkan, E.L., & Schetky, D. H. (1981). Treatment of child victims of incest. *American Journal of Family Therapy, 9*, 43-51.

Boekelheide, P.D. (1978). Incest and the family physician. *Journal of Family Practice, 6*, 87-90.

Brandt, R., & Tiza, V. (1977). The sexually misused child. *American Journal of Orthopsychiatry, 47*, 80-90.

Brassard, M.R., Tyler, A., & Kehle, T.J. (1983). Sexually abused children: Identification and suggestions for intervention. *School Psychology Review, 12*, 93-97.

Briere, J. N. (1992). *Child abuse trauma: Theory and treatment of the lasting effects*. Newbury Park, CA: Sage Publications.

Brooks, B. (1982). Familial influence on father-daughter incest. *Journal of Psychiatric Treatment and Evaluation, 4*, 117-124.

Browning, D. H., & Boatman, B. (1977). Incest: Children at risk. *American Journal of Psychiatry, 134*, 69-72.

Brunngraber, L.S. (1986). Father-daughter incest: Immediate and long-term effects of sexual abuse. *Advances in Nursing Science, 8* (4), 15-35.

Brunold, H. (1964). Observations after sexual traumata suffered in childhood. *Excerpta Criminologica, 11*, 60-66.

Bulik, C.M., Sullivan, P.F., & Rorty, M. (1989). Childhood sexual abuse in women with bulimia. *Journal of Clinical Psychiatry, 50*, 460-464.

Burgess, A.W., & Holmstrom, L.L. (1975). Sexual trauma of children and adolescents. *North American Journal of Clinical Nursing, 10*, 551-563.

Calam, R.M., & Slade, P.D. (1989). Sexual experience and eating problems in female undergraduates. *International Journal of Eating Disorders, 8*, 391-397.

Cavallin, H. (1966). Incestuous fathers: A clinical report. *American Journal of Psychiatry, 122*, 1132-1138.

Cohen, J. (1988). *Statistical power analysis in the social sciences*. Hillsdale, NJ: Lawrence Erlbaum.

Cohen, J. A. (1981). Theories of narcissism and trauma. *American Journal of Psychiatry, 35*, 83-100.

Cole, P. M., & Putnam, F. W. (1992). Effects of incest on self and social functioning: A developmental psychopathological perspective. *Journal of Consulting and Clinical Psychology, 60*(2), 174-184.

Cole, P. M., Woolger, C., Power, T. G., & Smith, K. D. (1992). Parenting difficulties among adult survivors of father-daughter incest. *Child Abuse and Neglect, 16* (2), 239-249.

Coleman, P. (1984). Incest: A proper definition reveals the need for a different legal response. *Missouri Law Review, 49*, 251-288.

Coons, P. M., & Milstein, V. (1986). Psychosocial disturbances in multiple personality: Characteristics, etiology, and treatment. *Journal of Clinical Psychiatry, 47*, 106-110.

Courtois, C.A. (1979). *Characteristics of a volunteer sample of adult women who experienced incest in childhood or adolescence.* Unpublished doctoral dissertation, University of Maryland.

Crowne, D., & Marlow, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24*, 349-354.

Crowne, D., & Marlow, D. (1964). *The approval motive.* New York: Wiley, 1964.

Daro, D., & McCurdy, K. (1992). *Current trends in child abuse reporting and fatalities: The results of the 1991 annual fifty states survey.* Chicago, IL: National Committee for the Prevention of Child Abuse.

Davidson, J.R., Hughes, D.C., George, L. F. & Blazer, D. G. (1996). The association of sexual assault and attempted suicide within the community. *Archives of General Psychiatry, 53* (6), 550-555.

Davis, M.H. (1996). *Empathy: A social psychological approach.* Madison, WI: Westview press.

De Francis, V. (1970). *Protecting the child victim of sex crimes committed by adults*. Denver, CO: American Humane Association.

Diaz, J. (1994). *The impact of sexual abuse on adolescent females: Factors influencing subsequent psychological adjustment and sexual behavior.* Unpublished doctoral dissertation, Columbia University.

Dixon, J., & Jenkins, J. O. (1981). Incestuous child sexual abuse: A review of treatment strategies. *Clinical Psychology Review, 1*, 211-222.

Doherty, W.J., & Ryder, R.G. (1979). Locus of control, interpersonal trust, and assertive behavior among newlyweds. *Journal of Personality and Social Psychology, 37* (12), 2212-2220.

Eisenberg, N., & Lennon, R. (1983). Sex differences in empathy and related capacities. *Psychological Bulletin, 101*, 91-119.

Elashoff, J. D. (1969). Analysis of covariance: A delicate instrument. *American Educational Research Journal, 6*, 383-401.

Evans, K., & Sullivan, J. M. (1995). *Treating addicted survivors of trauma.* New York: Guilford Press.

Finch, S. (1967). Sexual activity of children with other children and adults. *Clinical Pediatrics, 6*, 102.

Finch, S. (1973). Adult seduction of the child: Effects in the child. *Medical Aspects* of *Human Sexuality*, 7, 170-187.

Finkelhor, D. (1987). The sexual abuse of children: Current research reviewed. *Psychiatric Annals, 17*, 233-241.

Finkelhor, D. (1988). The trauma of child sexual abuse: Two models. In G.E. Wyatt & G.J. Powell (Eds.), *Lasting effects of child sexual abuse* (pp. 61-82). Beverly Hills, CA: Sage.

Finkelhor, D. (1994). The international epidemiology of child sexual abuse. *Child Abuse and Neglect, 18*, 409-417.

Finkelhor, D. (1995). The victimization of children: A developmental perspective. *American Journal of Orthopsychiatry, 65* (2), 177-192.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55* (4), 530-541.

Finkelhor, D., & Hotaling, G. (1984). Sexual abuse in the National Incidence Study of Child Abuse and Neglect. *Child Abuse and Neglect, 8*, 22-32.

Flathman, M. (1999). Trauma and delayed memory: A review of the "repressed memories" literature. *Journal of Child Sexual Abuse, 8* (2), 1-23.

Frenken, J., & Van Stolk, B. (1990). Incest victims: Inadequate help by professionals. *Child Abuse & Neglect, 14*, 253-263.

Freud, A. (1981). A psychoanalyst's view of sexual abuse by parents. In P. B.Mrazek & C.H. Kempe (Eds.), *Sexually abused children and their families* (pp.108-132). New York: Pergamon Press.

Friedrich, W.N. (1987). The sexual abuse of children: Current research reviewed. *Psychiatric Annals, 17*, 233-241.

Friedrich, W.N., Urquiza, S.J., Beilke, R. (1986). Behavioral problems in sexually abused young children. *Journal of Pediatric Psychology, 11*, 47-57.

Garry, M., & Loftus, E.F. (1994). Pseudomemories without hypnosis. *International Journal of Clinical and Experimental Hypnosis, 42* (4), 363-378.

Giovannoni, J.,& Beccera, R. (1979). *Defining child abuse*. New York Free Press.

Goodwin, J. (1982). The use of drawings in incest cases. In J. Goodwin (Ed.), *Sexual abuse: Incest victims and their families* (pp.155-168). Littleton, MA: John Wright.

Goodwin, J., Zouhar, M. S., & Bergman, R. (1989). Hysterical seizures in adolescent incest victims. In J. Goodwin (Ed.), *Sexual abuse: Incest victims and their families* (pp.177-189). Chicago: Year Book Medical.

Green, A. H. (1991). Factors contributing to false allegations of child sexual abuse and custody disputes. *Child and Youth Services, 15*, 177-189.

Green, A.H. (1996). Overview of child sexual abuse. In S.J. Kaplan (Ed.), *Family violence: A clinical and legal guide* (pp.73-105). Washington, DC: American Psychiatric Press.

Gross, M. (1982). Incest and hysterical seizures. *Medical Hypnoanalysis, 3,* 146-152.

Groth, A.N. (1982). The incest offender. In S. Sgroi (Ed.), *Handbook of clinical intervention in child sexual abuse* (pp. 204-237). Lexington, MA: Lexington Books.

Groth, A. N., & Birnbaum, H. J. (1978). Adult sexual orientation and attraction to underage persons. *Archives of Sexual Behavior, 7,* 175-181.

Harney, P. A. (1992). The role of incest in developmental theory and treatment of women diagnosed with borderline personality disorder. *Women and Therapy, 12* (1-2), 39-57.

Heims, L., & Kaufman, I. (1963). Variations on a theme of incest. *American Journal of Orthopsychiatry, 33,* 311-312.

Heise, D. (1969). Some methodological issues in semantic differential research. *Psychological Bulletin, 72,* 406-422.

Herman, J.L. (1981). Father-daughter incest. *Professional Psychology, 12,* 76-80.

Herman, J. L. (1992). *Trauma and recovery.* New York: Basic Books.

Herman, J.L., & Hirschman, L. (1977). Father-daughter incest: Signs. *Journal of Women in Culture and Society, 2,* 735-756.

Herman, J.L., & Hirschman, L. (1981). Families at risk for father-daughter incest. *American Journal of Psychiatry, 138*, 967-970.

Herman, J.L., Perry, J.C., & van der Kolk, B. A. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry, 146*, 490-495.

Herman, J. L., & van der Kolk, B. A. (1987). Traumatic antecedents of borderline personality disorder. In B.A. van der Kolk (Ed.), *Psychological Trauma* (p.111-126). Washington, DC: American Psychiatric Press.

Herzog, D.B., Staley, J. E., Carmody, S., Robbins, W.M., & van der Kolk, B.A. (1993). Childhood sexual abuse in anorexia nervosa and bulimia nervosa: A pilot study. *Journal of Counseling Psychology, 42*, 178-186.

Hotte, J., & Rafman, S. (1992). The specific effects of incest on prepubertal girls from dysfunctional families. *Child Abuse and Neglect, 16* (2), 273-283.

Huitema, B.E. (1980). *Analysis of covariance and its alternatives*. New York: John Wiley & Sons.

Hussey, D., & Singer, M. (1993). Sexual and physical abuse: The adolescent sexual concern questionnaire (ASC). In M.I. Singer, L.T. Singer, & T.M. Anglin (Eds.), *Handbook for screening adolescents at psychosocial risk* (pp. 131-163). New York: Lexington Books.

Jiles, D. (1981). Problems in the assessment of sexual abuse referrals. In W. Holder (Ed.), *Sexual abuse of children* (pp. 118-146). New York: Pergamon Press.

Johnston, M. S. K. (1979). *Nonincestuous sexual abuse of children and its relationship to family dysfunction.* Paper presented at the Fourth National Conference on Child Abuse and Neglect, Los Angeles.

Factors assisting female clients' disclosure of incest during counseling. *Journal of Counseling and Development, 65* (9), 475-478.

Josephson, H., & Fong-Beyette, D. (1987). The nature and substantiation of official sexual abuse reports. *Children Today, 16*, 23-27

Juska, M. A. (1998). *Maternal attachment and childhood sexual abuse.* Unpublished doctoral dissertation, Long Island University.

Kaiser, H. (1958). The varimax criterion for analytic rotation in factor analysis. *Psychometrica, 22*, 187-200.

Kaplan, S. J. (1996). *Family violence: A clinical and legal guide.* Washington, DC: American Psychiatric Press.

Kearney-Cooke, A. (1988). Group treatment of sexual abuse among women with eating disorders. *Women & Therapy, 7*, 5-21.

Kelly, R. J. (1982). Behavioral reorientation of pedophiliacs: Can it be done? *Clinical Psychology Review, 2*, 387-408.

Kerlinger, F. N. (1972). *Foundations of behavioral research* (2nd ed.). New York: Holt, Rinehart, & Winston.

Kluft, R. (1985). *Childhood antecedents of multiple personality.* Washington, DC: 1985.

Kluft, R. P., Steinberg, M., & Spitzer, R. L. (1988). DSM-III-R revisions in the dissociative disorders: An explanation of their observation and rationale. *Dissociation, 1,* 39-46.

Knittle, B. J., & Tuana, S. (1980). Group therapy as primary treatment for adolescent victims of intrafamilial sexual abuse. *Clinical Social Work Journal, 8,* 236-242.

Korte, K.I., Horton, C. B., & Graybill, D. (1998). Child sexual abuse and bulimic behaviors: An exploratory investigation of the frequency and nature of a relationship. *Journal of Child Sexual Abuse, 7* (1), 53-64.

Krieger, M. J., Rosenfeld, A. A., Gordon, A., & Bennett, M. (1980). Problems in psychotherapy of children with histories of incest. *American Journal of Psychotherapy, 34,* 81-88.

Krystal, H. (1982). Alexithymia and the effectiveness of psychoanalytic treatment. *International Journal of Psychoanalytic Psychotherapy, 9,* 353-378.

Lacey, J. H. (1990). Incest, incestuous fantasy & indecency: A clinical catchment area study of normal-weight bulimic women. *British Journal of Psychiatry, 157,* 399-403.

Lefcourt, H.M. (1976). *Locus of control: Current trends in theory and research.* Hillsdale, NJ: Erlbaum.

Lefcourt, H.M. (1990). Locus of Control. In J.R. Robinson & P.R. Shaver (Eds.). *Measures of Personality and Social Psychological Attitudes* (pp. 231-234) New York: Elsevier Science and Technology.

Lefcourt, H.M. (1991). *Locus of Control in Measures of Personality and Social Psychological Attitudes*. New York: Academic Press.

Lindsay, D. S., & Briere, J. (1997). The controversy regarding recovered memories of childhood sexual abuse: Pitfalls, bridges, and future directions. *Journal of Interpersonal Violence*, 12 (5), 631-647.

Links, P.S., Steiner, M., & Offord, D.R. (1988). Characteristics of borderline personality: A Canadian study. *Canadian Journal of Psychiatry, 33*, 336-340.

Livingston, R. (1987). Sexually and physically abused children. *Journal of the American Academy of Child and Adolescent Psychiatry, 27*, 413-415.

Loftus, E.F. (1992). When a lie becomes memory's truth: Memory distortion after exposure to misinformation. *Current Directions in Psychological Science, 1* (4), 121-123.

Loftus, E.F. (1993). The reality of repressed memories. *American Psychologist, 48* (5), 518-537.

Loftus, E.F. (1994). The repressed memory controversy (a response to comments). *American Psychologist*, 49 (5), 443-445.

Lusk, R., & Waterman, J. (1986). Effects of sexual abuse on children. In K. MacFarlane & J. Waterman (Eds.). *Sexual abuse of young children* (pp.18-36). New York: The Guilford Press.

Lustig, N., Dresser, J., & Spelman, S. (1966). Incest. *Archives of General Psychiatry, 14*, 31-40.

MacFarlane, K., & Korbin, J. (1983). Confronting the incest secret long after the fact: A family study of multiple victimization with strategies for intervention. *Child Abuse and Neglect, 7*, 225-240.

Meiselman, K. (1978). *Incest: A psychological study of causes and effects with treatment recommendations.* San Francisco: Jossey-Bass.

Meiselman, K. (1990). *Resolving the trauma of incest.* San Francisco: Jossey-Bass.

Miller, D.A.F., McCluskey-Fawcett, K., & Irving, L.M. (1993). The relationship between childhood sexual abuse and subsequent onset of bulimia nervosa. *Child Abuse & Neglect, 17*, 305-314.

Morrison, N.C., & Clavenna-Valleroy, J. (1998). Perceptions of maternal support as related to self-concept and self-report of depression in sexually abused female adolescents. *Journal of Child Sexual Abuse, 7* (1), 23-40.

Mrazek, P.B., & Mrazek, D.A. (1981). The effects of child sexual abuse: Methodological considerations. In P.B. Mrazek & H. Kempe. (Eds.) *Sexually abused children and their families* (pp. 245-259). New York: Pergamon.

Nash, M. R. (1994). Memory distortion and sexual trauma: The problem of false negatives and false positives. *International Journal of Clinical and Experimental Hypnosis, 42* (4), 346-362.

National Center on Child Abuse and Neglect (1978). *Child sexual abuse: Incest, assault, and exploitation* (DHHS Publication No. OHDS 79-30166. Washington, DC: U.S. Government Printing Office.

National Victims Center (1996). *Child sexual abuse*. Washington, DC: U.S. Government Printing Office.

Olio, K.A., & Cornell, W.F. (1994). Making meaning not monsters: Reflections on the delayed memory controversy. *Journal of Child Sexual Abuse, 3* (3), 77-94.

Orgata, S.N., Silk, K.R., & Goodrich, S. (1990). Childhood physical and sexual abuse in adult patients with borderline personality disorder. *American Journal of Psychiatry, 147*, 1498-1499.

Osgood, C.E., Suci, G., & Tannenbaum, P. (1957). *The measurement of meaning*. Urbana, IL: University of Illinois Press.

Perlmutter, L. H., Engel, T., & Sager, C. J. (1982). The incest taboo: Loosened sexual boundaries in remarried families. *Journal of Sex and Marital Therapy, 8*, 83-96.

Powell, G. E., & Chalkley, A.J. (1981). The effects of paedophile attention on the child. In B. Taylor (Ed.), *Perspectives on paedophilia* (pp. 38-64). London: Batsford.

Pribor, E. F., & Dinwiddie, S. H. (1992). *American Journal of Psychiatry, 149* (1), 52-56.

Prozan, C. (1999). *Construction and reconstruction of memory: Dilemmas of childhood sexual abuse*. Northvale, NJ: Jason Aronson.

Putnam, F. W. (1985). Dissociation as a response to extreme trauma. In R. Kluft, (Ed.), *Childhood antecedents of multiple personality* (pp. 113-145). Washington, DC: American Psychiatric Press.

Riggs, R. S. (1982). Incest: The school's role. *Journal of School Health, 52,* 365-370.

Rogers, C., & Terry, T. (1984). Clinical intervention with boy victims of sexual abuse. In I. Stewart & J. Green (Eds.). *Victims of sexual aggression* (pp. 38-59). New York: Van Nostrand Reinhold.

Root, M. P. P., & Fallon, P. (1989). Treating the victimized bulimic: The functions of binge-purge behavior. *Journal of Interpersonal Violence, 4,* 90-100.

Rosenfeld, A. A., Nadelson, C. C., & Krieger, M. (1979). Fantasy and reality in patients' reports of incest. *Journal of Clinical Psychiatry, 40,* 159-164.

Rosenfeld, A. A., Nadelson, C. C., Krieger, M., & Backman, J. J. (1977). Incest and sexual abuse of children. *Journal of the American Academy of Child Psychiatry, 16,* 327-339.

Rotter, J.B. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs: General and Applied, 80* (1), 1-28.

Rotter, J.B. (1990). Internal versus external control of reinforcement: A case history of a variable. *American Psychologist, 45* (4), 489-493.

Rotter, J.B., Seeman, M., & Liverant, S. (1962). Internal versus external control of reinforcement: A major variable in behavior therapy. In N.F. Washburn (Vol. Ed.), *Vol. 2. Decisions, values, and groups* (pp. 61-89). London: Pergamon Press.

Russell, D. E. (1983). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. *Child Abuse and Neglect, 7*, 133-146.

Russell, D. E. (1986). *The secret trauma: Incest in the lives of girls and women.* Beverley Hills, CA: Sage.

Salzman, J. P., Salzman, C., & Wolfson, A.N. (1993). Association between borderline personality structure and history of childhood abuse in adult volunteers. *Comparative Psychiatry, 34*, 254-257.

Sarbin, T. R. (1997). The poetics of identity. *Theory and Psychology, 7* (1), 67-82.

Scher, D., & Twaite, J. A. (1999). The relationship between child sexual abuse and alexithymic symptoms in a population of recovering adult substance abusers. *Journal of Child Sexual Abuse, 8* (2), 25-40.

Sgroi, S. M. (1982). *Handbook of clinical intervention in child sexual abuse.* Lexington, MA: Lexington Books.

Sgroi, S.M., Blick, L.C., & Porter, F.S. (1982). A conceptual framework for child sexual abuse. In Sgroi, S.M. (Ed.), *Handbook of clinical intervention in child sexual abuse* (pp. 47-72). Lexington, MA: Lexington Books.

Shaw, V. L., & Meier, J. H. (1983). *The effect of type of abuse and neglect on children's psychosocial development.* Dobbs Ferry, NY: The Children's Village.

Shearer, S.L., Peters, C. P., & Quaytman, M. S. (1993). Frequency and correlates of childhood sexual and physical abuse histories in adult female borderline inpatients. *American Journal of Psychiatry, 147*, 214-216.

Sifneos, P. E. (1973). The prevalence of alexithymic characteristics in psychosomatic patients. *Psychotherapy and Psychosomatic Medicine, 22*, 255-262.

Sifneos, P. E. (1975). Problems of psychotherapy of patients with alexithymic characteristics and physical disease. *Psychotherapy and Psychosomatic Medicine, 26*, 65-70.

Simari, C.G., & Baskin, D. (1982). Incestuous experiences within homosexual populations: A preliminary study. *Archives of Sexual Behavior, 11*, 329-344.

Simpson, C.A., & Porter, G. L. (1981). Self-mutilation in children and adolescents. *Bulletin of the Menninger Clinic, 45*, 428-438.

Smolak, L., Levine, M.P., & Sullins, E. (1990). Are child sexual experiences related to eating-disordered attitudes and behaviors in a college sample? *International Journal of Eating Disorders, 9*, 167-178.

Spence, J. T., & Helmrich, R. L. (1978). *Masculinity and femininity: Their psychological dimensions, correlates, & antecedents.* Austin, TX: University of Texas Press.

Spencer, J. (1978). Father-daughter incest: A clinical view from the corrections field. *Child Welfare, 57,* 581-590.

Steele, B. (1981). Long-term effects of sexual abuse in childhood. In P.B. Mrazek & C. H. Kempe (Eds.), *Sexually abused children and their families* (pp. 55-68). New York: Pergamon Press.

Steele, B. (1990). Some sequelae of the sexual maltreatment of children. In H.B. Levine (Ed.), *Adult analysis and childhood sexual abuse* (pp. 21-34). Hillsdale, NJ: The Analytic Press.

Steele, B. F., & Alexander, H. (1981). Long term effects of sexual abuse in childhood. In P.B. Mrazek & C.H. Kempe (Eds.), *Sexually abused children and their families* (pp. 229-244). New York: Pergamon Press.

Steinberg, M. (1995). *Handbook for the assessment of dissociation: A clinical guide.* Washington, DC: American Psychiatric Press.

Stern, C. R. (1984). The etiology of multiple personalities. *Psychiatric Clinics of North America, 7,* 149-160.

Stevens, J. (1996). *Applied multivariate statistics for the social sciences* (3rd ed.). Mahwah, NJ: Lawrence Erlbaum Associates.

Strahan, R., & Gerbasi, K.C. (1972). Short, homgeneous versions of the Marlowe-Crowne Social Desirability Scale. *Journal of Clinical Psychology, 28,* 191-193.

Summit, R. (1983). The child sexual abuse accommodation syndrome. *Child Abuse and Neglect*, 7, 177-193.

Tormes, Y.M. (1968). *Child victims of incest.* Denver, CO: American Humane Association.

Tsai, M., & Wagner, N. (1978). Incest and molestation: Problems of childhood sexuality. *Medical Times*, 16-22.

Tufts New England Medical Center, Division of Child Psychiatry. (1984). *Sexually exploited children: Service and research project (Final report for the Office of Juvenile Justice and Delinquency Prevention).* Washington, DC: U.S. Department of Justice.

U.S. Department of Health & Human Services (1981). *Child sexual abuse: Incest, assault and sexual exploitation.* Washington, DC: U.S. Government Printing Office.

U.S. Department of Health & Human Services (amended Nov. 1992). *Child Abuse Prevention & Treatment Act,* Washington, DC: U.S. Government Printing Office.

U.S. Department of Health & Human Services. (1995). *Child maltreatment 1993: Reports from the states to the National Center on Child Abuse and Neglect.* Washington, DC: U.S. Government Printing Office.

U.S. Department of Health & Human Services. (2002). *Child maltreatment 2000: Reports from the states to the National Center on Child Abuse and Neglect.* Washington, DC: U.S. Government Printing Office.

7. a. No matter how hard you try, some people just don't like you.

   b. People who can't get others to like them don't understand how to get along with others.

8. a. Heredity plays the major role in determining one's personality.

   b. It is one's experiences in life that determine what they're like.

9. a. I have often found that what is going to happen will happen.

   b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10. a. In the case of the well prepared student there is rarely if ever such a thing as an unfair test.

    b. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.

    b. Getting a good job depends mainly on being in the right place at the right time.

12. a. The average citizen can have an influence in government decisions.

    b. This world is run by the few people in power, and there is not much the little guy can do about it.

13. a. When I make plans, I am almost certain that I can make them work.

    b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14. a. There are certain people who are just no good.

    b. There is some good in everybody.

15. a. In my case getting what I want has little or nothing to do with luck.

    b. Many times we might just as well decide what to do by flipping a coin.

16. a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.

    b. Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.

17. a. As far as world affairs are concerned, most of us are victims of forces we can neither understand, nor control.

    b. By taking an active part in political and social affairs the people can control world events.

18. a. Most people don't realize the extent to which their lives are controlled by accidental happenings.

    b. There really is no such thing as "luck."

19. a. One should always be willing to admit mistakes.

    b. It is usually best to cover up one's mistakes.

20. a. It is hard to know whether or not a person really likes you.

    b. How many friends you have depends upon how nice a person you are.

21. a. In the long run the bad things that happen to us are balanced by the good ones.

    b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. a. With enough effort we can wipe out political corruption.

    b. It is difficult for people to have much control over the things politicians do in office.

23. a. Sometimes I can't understand how teachers arrive at the grades they give.

    b. There is a direct connection between how hard I study and the grades I get.

24. a. A good leader expects people to decide for themselves what they should do.

    b. A good leader makes it clear to everybody what their jobs are.

25. a. Many times I feel that I have little influence over the things that happen to me.

    b. It is impossible for me to believe that chance or luck plays an important role in my life.

26. a. People are lonely because they don't try to be friendly.

    b. There's not much use in trying too hard to please people, if they like you, they like you.

27. a. There is too much emphasis on athletics in high school.

    b. Team sports are an excellent way to build character.

28. a. What happens to me is my own doing.

    b. Sometimes I feel I don't have enough control over the direction my life is taking.

29. a. Most of the time I can't understand why politicians behave the way they do.

    b. In the long run the people are responsible for bad government on a national as well as on a local level.

PART FOUR:

Please indicate whether each of the following statements is true of you or whether it is false:

	check one: true	false
1. I'm always willing to admit it when I make a mistake.	___	___
2. I like to gossip at times.	___	___
3. I always try to practice what I preach.	___	___
4. There have been occasions when I took advantage of someone.	___	___
5. I never resent being asked to return a favor.	___	___
6. I sometimes try to get even rather than forgive and forget.	___	___
7. I have never been irked when people expressed ideas very different from my own.	___	___
8. At times I have really insisted on having things my own way.	___	___
9. I have never deliberately said something that hurt someone's feelings.	___	___
10. There have been occasions when I felt like smashing things.	___	___

PART FIVE:

Now, if you will, please respond to the following questions that pertain to your demographic characteristics and training experiences:

1. your gender (check one): ____female
____male

2. your age (fill in) ____years

3. your professional discipline (check one):

___ social worker
___clinical psychologist
___counseling psychologist
___psychiatrist
___marriage/family therapist
___school counselor
___school psychologist
___ counselor
___psychotherapist
___other (please specify)_____

4. Your highest degree (check one):

___bachelor's degree
___master's degree
___doctoral degree

5. your total years of clinical experience (fill in) ____ years

6. Did you take any courses in school that were concerned with any of the following areas? (check yes or no for each)

	yes	no
psychopathology	___	___
suicide	___	___
phobias	___	___
incest	___	___
learning disabilities	___	___
child abuse	___	___
substance abuse	___	___
attention deficit disorder	___	___
anxiety	___	___
occupational stress	___	___
physical abuse	___	___
adjustment disorder	___	___
depression	___	___
marital conflict	___	___
school resistance	___	___
schizophrenia	___	___
psychosis	___	___
juvenile delinquency	___	___

7. Have you had any inservice educational experiences that were concerned with any of the following areas? (check yes or no for each area):

	yes	no
psychopathology	___	___
suicide	___	___
phobias	___	___
incest	___	___
learning disabilities	___	___
child abuse	___	___
substance abuse	___	___
attention deficit disorder	___	___
anxiety	___	___
occupational stress	___	___
physical abuse	___	___
adjustment disorder	___	___
depression	___	___
marital conflict	___	___
school resistance	___	___
schizophrenia	___	___
psychosis	___	___
juvenile delinquency	___	___

8. Have you had experience working with families in which any of the following have occurred? (check yes or no for each area):

	yes	no
psychopathology	___	___
suicide	___	___
phobias	___	___
incest	___	___
learning disabilities	___	___
child abuse	___	___
substance abuse	___	___
attention deficit disorder	___	___
anxiety	___	___
occupational stress	___	___
physical abuse	___	___
adjustment disorder	___	___
depression	___	___
marital conflict	___	___
school resistance	___	___
schizophrenia	___	___
psychosis	___	___
juvenile delinquency	___	___

9. For each area in which your answer to question 8 was yes, please indicate the number of such cases: (fill in number):

psychopathology	___	cases
suicide	___	cases
phobias	___	cases
incest	___	cases
learning disabilities	___	cases
child abuse	___	cases
substance abuse	___	cases
attention deficit disorder	___	cases
anxiety	___	cases
occupational stress	___	cases
physical abuse	___	cases
adjustment disorder	___	cases
depression	___	cases
marital conflict	___	cases
school resistance	___	cases
schizophrenia	___	cases
psychosis	___	cases
juvenile delinquency	___	cases

10. What is your professional orientation/training? (check one):

ego psychology	___
object relations	___
self psychology	___
systemic	___
cognitive/behavioral	___
rational-emotive	___
family systems	___
psychodynamic	___
behavioral	___
psychoanalytical	___
transactional analytic	___
other (specify) _____	

Appendix B

Factor Solutions for Twelve Vignettes by Stimulus Individual Combinations

Table B.1
Rotated Component Matrix for Four Factor Solution of Semantic Differential Ratings of Incest Victim

Item	Component 1	2	3	4
24. sociable.....unsociable	.87	-.01	.11	.29
25. large.....small	.65	-.03	-.02	.34
26. clean.....dirty	.24	.33	.87	.07
27. healthy..... sick	.07	.83	.07	-.12
28. good.....bad	.22	.55	.61	.19
29. sad.....happy	-.69	.42	-.30	-.05
30. weak.....strong	-.44	-.01	-.35	-.05
31. honest.....dishonest	-.04	-.19	.85	.23
32. delicate.....rugged	.00	-.40	.10	.20
33. beautiful.....ugly	.17	.14	.90	.11
34. blameless.....blameworthy	-.30	$.87_a$	-.06	.15
35. tense.....relaxed	-.46	.70	.07	.33
36. loud.....quiet	.52	.33	-.64	.30
37. intact.....damaged	-.05	.06	-.18	-.91
38. anxious.....calm	-.50	.29	-.37	.40
39. innocent.....guilty	-.27	$.83_a$	.02	.18
40. isolated.....connected	-.80	.18	-.15	.17
41. wrong.....right	.55	$-.50_a$	-.30	.01
42. responsible.....not responsible	.36	$-.82_a$	-.07	-.19
43. fast.....slow	.69	-.23	.23	-.27
44. controlling.....controlled	.69	-.21	.02	-.04
45. active.....passive	.57	-.59	-.12	-.36
46. damaged.....intact	.17	.20	.16	.87

Note. The loadings of items 11, 16, 18, and 19 on attribution of blame factor are denoted by $_a$.

Table B.2
Rotated Component Matrix for Four Factor Solution of Semantic Differential Ratings of Father of Incest Victim

Item	Component 1	2	3	4
1. sociable.....unsociable	-.32	-.02	.81	-.29
2. large.....small	.20	.78	.04	-.41
3. clean.....dirty	-.30	.08	.65	.10
4. healthy..... sick	.01	-.12	.83	.17
5. good.....bad	.10	-.11	.29	.15
6. sad.....happy	.62	.62	-.13	-.01
7. weak.....strong	.83	-.14	.02	.15
8. honest.....dishonest	.22	-.13	.72	.41
9. delicate.....rugged	.22	-.04	.21	.84
10. beautiful.....ugly	-.12	.00	.33	.77
11. blameless.....blameworthy	-.94 $_a$	-.13	.16	-.02
12. tense.....relaxed	.26	.61	-.22	.24
13. loud.....quiet	.64	.13	.12	-.71
14. intact.....damaged	-.83	-.33	.01	-.05
15. anxious.....calm	.79	.04	.03	.03
16. innocent.....guilty	-.97 $_a$	-.06	.12	.11
17. isolated.....connected	.23	.62	-.15	.30
18. wrong.....right	.57 $_a$	.58	-.34	.32
19. responsible.....not responsible	.78 $_a$	.31	-.26	.07
20. fast.....slow	.09	.84	-.35	-.07
21. controlling.....controlled	.09	.38	-.73	.06
22. active.....passive	-.24	.66	-.06	-.20
23. damaged.....intact	.24	.31	-.37	.43

Note. The loadings of items 11, 16, 18, and 19 on attribution of blame factor are denoted by $_a$.

Table B.3
Rotated Component Matrix for Four Factor Solution of Semantic Differential Ratings of Mother of Incest Victim

Item	Component 1	2	3	4
1. sociable.....unsociable	.75	.50	.23	.11
2. large.....small	-.25	.09	.63	-.35
3. clean.....dirty	.77	.21	-.44	.11
4. healthy..... sick	.82	.32	-.23	.11
5. good.....bad	.69	.35	-.07	.07
6. sad.....happy	-.08	-.68	.12	.53
7. weak.....strong	-.70	-.26	.15	-.07
8. honest.....dishonest	.36	.55	.12	.13
9. delicate.....rugged	.21	.06	-.88	.14
10. beautiful.....ugly	.04	.85	.15	-.05
11. blameless.....blameworthy	-.86$_a$	-.05	.00	-.07
12. tense.....relaxed	-.27	-.34	-.01	.84
13. loud.....quiet	-.17	.17	.90	.12
14. intact.....damaged	.69	.30	-.12	.09
15. anxious.....calm	-.25	-.79	-.04	.37
16. innocent.....guilty	-.82$_a$	-.09	-.33	-.41
17. isolated.....connected	-.63	-.67	-.14	.07
18. wrong.....right	-.88$_a$	.01	.19	.28
19. responsible.....not responsible	-.82$_a$	.08	.22	.33
20. fast.....slow	.13	.60	-.30	.06
21. controlling.....controlled	.02	.04	.25	-.84
22. active.....passive	.11	.81	.19	-.47
23. damaged.....intact	-.73	-.35	.17	.18

Note. The loadings of items 11, 16, 18, and 19 on attribution of blame factor are denoted by $_a$.

Table B.4
Rotated Component Matrix for Four Factor Solution of Semantic Differential Ratings of Victim of Physical Abuse

Item	Component 1	2	3	4
1. sociable.....unsociable	.17	-.22	.72	.42
2. large.....small	.15	-.31	.77	.29
3. clean.....dirty	-.37	-.75	-.28	-.04
4. healthy..... sick	-.04	-.75	-.08	-.03
5. good.....bad	-.32	-.21	-.14	.49
6. sad.....happy	-.53	.45	.10	.43
7. weak.....strong	-.24	.86	-.24	.00
8. honest.....dishonest	-.17	-.14	.06	.65
9. delicate.....rugged	-.21	.57	-.03	-.18
10. beautiful.....ugly	-.11	-.01	.13	.78
11. blameless.....blameworthy	.36	.33	-.49$_a$	.60
12. tense.....relaxed	-.58	.36	.01	.22
13. loud.....quiet	.39	.13	.69	-.03
14. intact.....damaged	.91	-.06	.05	-.05
15. anxious.....calm	-.35	.46	-.40	-.33
16. innocent.....guilty	.25	-.02	-.75$_a$	.15
17. isolated.....connected	-.04	-.11	-.53	.04
18. wrong.....right	.78	.19	.50$_a$	-.01
19. responsible.....not responsible	.18	.01	.44$_a$	.00
20. fast.....slow	.06	-.48	.44	-.40
21. controlling.....controlled	.93	-.11	.05	-.06
22. active.....passive	.81	-.18	.37	-.15
23. damaged.....intact	-.40	.65	.01	-.45

Note. The loadings of items 11, 16, 18, and 19 on attribution of blame factor are denoted by $_a$.

Table B.5
Rotated Component Matrix for Four Factor Solution of Semantic Differential Ratings of Father of Victim of Physical Abuse

Item	Component 1	2	3	4
1. sociable.....unsociable	.21	.48	.46	-.14
2. large.....small	-.29	-.09	.33	.69
3. clean.....dirty	.68	.02	.53	.08
4. healthy..... sick	.80	.12	.26	.09
5. good.....bad	.92	-.04	.07	.00
6. sad.....happy	.06	.12	-.06	.89
7. weak.....strong	.01	.75	-.35	.32
8. honest.....dishonest	.86	-.02	.05	.00
9. delicate.....rugged	.43	.69	.09	.12
10. beautiful.....ugly	.62	.33	.32	-.17
11. blameless.....blameworthy	.31	-.06 $_a$	-.30	.02
12. tense.....relaxed	-.01	-.24	.47	.07
13. loud.....quiet	-.55	-.61	.13	.09
14. intact.....damaged	-.04	.02	-.83	-.04
15. anxious.....calm	.05	-.09	.85	-.13
16. innocent.....guilty	.07	.73 $_a$	-.14	-.35
17. isolated.....connected	.09	-.36	-.23	.72
18. wrong.....right	-.56	.02 $_a$	.22	-.08
19. responsible.....not responsible	.26	-.84 $_a$	.21	.16
20. fast.....slow	-.43	.04	.09	.44
21. controlling.....controlled	.32	-.39	.07	.79
22. active.....passive	.20	-.58	-.25	.16
23. damaged.....intact	.26	.11	.74	.45

Note. The loadings of items 11, 16, 18, and 19 on attribution of blame factor are denoted by $_a$.

Table B.6
Rotated Component Matrix for Four Factor Solution of Semantic Differential Ratings of Mother of Victim of Physical Abuse

Item	Component 1	2	3	4
1. sociable.....unsociable	.08	-.28	-.04	.94
2. large.....small	.03	-.29	-.01	.90
3. clean.....dirty	.52	.30	.73	-.05
4. healthy..... sick	.68	.06	.44	.30
5. good.....bad	.39	.21	.58	.43
6. sad.....happy	-.69	.26	-.23	-.48
7. weak.....strong	-.18	.85	-.20	-.31
8. honest.....dishonest	.36	-.16	.78	-.21
9. delicate.....rugged	.25	.84	.14	-.02
10. beautiful.....ugly	.04	-.06	.93	.13
11. blameless.....blameworthy	.93 [a]	.04	.03	.19
12. tense.....relaxed	.02	.79	.11	-.12
13. loud.....quiet	.11	-.83	-.11	-.17
14. intact.....damaged	.95	-.05	-.22	-.09
15. anxious.....calm	.08	.65	.17	-.25
16. innocent.....guilty	-.88 [a]	.12	.01	-.13
17. isolated.....connected	.13	.80	.06	-.23
18. wrong.....right	-.89 [a]	-.02	-.05	-.05
19. responsible.....not responsible	-.95 [a]	.02	-.02	-.11
20. fast.....slow	.08	-.62	-.51	.38
21. controlling.....controlled	.31	-.30	-.74	.18
22. active.....passive	.39	-.57	-.05	.46
23. damaged.....intact	-.35	.30	.76	.10

Note. The loadings of items 11, 16, 18, and 19 on attribution of blame factor are denoted by [a].

Table B.7
Rotated Component Matrix for Four Factor Solution of Semantic Differential Ratings of Child with ADHD

Item	Component 1	2	3	4
1. sociable.....unsociable	-.23	-.02	.72	.07
2. large.....small	.01	.44	.69	-.07
3. clean.....dirty	-.12	-.14	.50	-.32
4. healthy..... sick	-.50	.07	.27	-.66
5. good.....bad	-.36	.72	-.23	-.20
6. sad.....happy	.34	.72	.04	.26
7. weak.....strong	.72	-.24	-.14	.27
8. honest.....dishonest	-.36	.61	-.25	-.19
9. delicate.....rugged	.88	-.18	-.20	-.11
10. beautiful.....ugly	-.66	.59	.13	-.16
11. blameless.....blameworthy	.00	.83 $_a$	-.05	.41
12. tense.....relaxed	.80	.17	-.21	.28
13. loud.....quiet	.04	.07	.80	-.01
14. intact.....damaged	-.77	-.20	.01	.05
15. anxious.....calm	.78	-.03	-.30	.16
16. innocent.....guilty	.23	.15	-.15	.69
17. isolated.....connected	.79	-.11	-.15	-.37
18. wrong.....right	.45	-.65 $_a$	-.10	.07
19. responsible.....not responsible	-.06	-.50 $_a$	-.16	-.43
20. fast.....slow	-.14	-.02	.13	.85
21. controlling.....controlled	-.29	-.69	-.20	-.04
22. active.....passive	-.47	-.30	.58	.27
23. damaged.....intact	.86	-.09	.20	.29

Note. The loadings of items 11, 16, 18, and 19 on attribution of blame factor are denoted by $_a$.

Table B.8
Rotated Component Matrix for Four Factor Solution of Semantic Differential Ratings of Father of Child with ADHD

Item	Component 1	2	3	4
1. sociable.....unsociable	.52	.04	.63	.23
2. large.....small	-.06	-.03	.82	.13
3. clean.....dirty	.38	-.24	.84	-.08
4. healthy..... sick	.86	-.28	.27	-.02
5. good.....bad	.84	-.23	.30	-.21
6. sad.....happy	-.03	.74	-.48	-.15
7. weak.....strong	-.08	.44	-.29	-.68
8. honest.....dishonest	.27	-.81	.25	-.05
9. delicate.....rugged	-.11	.62	-.04	-.22
10. beautiful.....ugly	.38	-.45	.43	-.25
11. blameless.....blameworthy	.73 [a]	-.52	.11	-.07
12. tense.....relaxed	-.19	.65	.53	.15
13. loud.....quiet	-.30	.60	.35	.12
14. intact.....damaged	.88	-.01	-.18	.07
15. anxious.....calm	-.51	.40	.10	.26
16. innocent.....guilty	.85 [a]	-.06	-.04	-.21
17. isolated.....connected	-.21	.83	-.03	-.02
18. wrong.....right	-.66 [a]	.57	-.11	.01
19. responsible.....not responsible	.71 [a]	.55	-.13	-.09
20. fast.....slow	-.04	.65	-.04	.58
21. controlling.....controlled	-.63	.01	-.09	.64
22. active.....passive	-.21	.02	.10	.81
23. damaged.....intact	-.82	.24	-.24	.22

Note. The loadings of items 11, 16, 18, and 19 on attribution of blame factor are denoted by [a].

Table B.9
Rotated Component Matrix for Four Factor Solution of Semantic Differential Ratings of Mother of Child with ADHD

Item	Component 1	2	3	4
1. sociable.....unsociable	-.27	.25	.82	.42
2. large.....small	-.04	.08	-.10	.98
3. clean.....dirty	.05	.96	-.12	.18
4. healthy..... sick	-.12	.81	.41	.26
5. good.....bad	-.11	.81	.41	.04
6. sad.....happy	.87	.27	-.28	-.27
7. weak.....strong	.78	-.60	-.13	.09
8. honest.....dishonest	.01	.93	.07	-.16
9. delicate.....rugged	.24	.60	-.74	.05
10. beautiful.....ugly	.05	.96	-.12	.18
11. blameless.....blameworthy	-.56	.66 [a]	.13	-.16
12. tense.....relaxed	.81	.29	-.33	.20
13. loud.....quiet	-.27	-.06	.93	-.14
14. intact.....damaged	-.95	.14	.25	-.08
15. anxious.....calm	.93	.04	-.28	-.05
16. innocent.....guilty	-.49	.83	-.06	.00
17. isolated.....connected	.36	-.41	-.60	.14
18. wrong.....right	.66	-.62 [a]	-.09	.18
19. responsible.....not responsible	.65	-.72	-.01	.17
20. fast.....slow	-.26	.22	.95	-.13
21. controlling.....controlled	-.92	.32	.19	-.04
22. active.....passive	-.92	.30	.12	.18
23. damaged.....intact	.96	-.10	-.20	-.02

Note. The loadings of items 11, 16, 18, and 19 on attribution of blame factor are denoted by [a].

Table B.10
Rotated Component Matrix for Four Factor Solution of Semantic Differential Ratings of Child with Schizophrenia

Item	Component 1	2	3	4
1. sociable.....unsociable	.02	.05	.08	.69
2. large.....small	.34	.37	.44	.19
3. clean.....dirty	-.06	.20	-.32	.76
4. healthy..... sick	-.09	.31	.14	.78
5. good.....bad	-.24	.53	-.26	.30
6. sad.....happy	-.22	-.34	.83	.22
7. weak.....strong	-.09	-.42	.81	-.08
8. honest.....dishonest	-.07	.89	.04	.13
9. delicate.....rugged	-.27	.25	.45	.10
10. beautiful.....ugly	-.04	.58	-.19	.57
11. blameless.....blameworthy	-.89 $_a$	.15	.25	-.17
12. tense.....relaxed	.04	-.75	.21	.30
13. loud.....quiet	.73	-.19	-.47	.07
14. intact.....damaged	-.01	.87	-.04	.25
15. anxious.....calm	.26	-.62	-.08	-.49
16. innocent.....guilty	-.87 $_a$	-.25	.20	.11
17. isolated.....connected	-.09	-.11	.69	-.28
18. wrong.....right	.56 $_a$	.10	.68	-.15
19. responsible.....not responsible	.92 $_a$	-.22	-.13	.04
20. fast.....slow	.88	.09	.03	-.31
21. controlling.....controlled	.90	-.13	.10	.05
22. active.....passive	.77	-.15	.22	.17
23. damaged.....intact	-.34	.11	.07	-.72

Note. The loadings of items 11, 16, 18, and 19 on attribution of blame factor are denoted by $_a$.

Table B.11
Rotated Component Matrix for Four Factor Solution of Semantic Differential Ratings of Father of Child with Schizophrenia

Item	Component 1	2	3	4
1. sociable.....unsociable	-.14	.80	-.18	.18
2. large.....small	-.06	.50	-.06	.75
3. clean.....dirty	.00	.87	.13	.14
4. healthy..... sick	-.62	.64	-.18	.18
5. good.....bad	-.67	.58	-.10	.18
6. sad.....happy	.17	-.19	.12	.59
7. weak.....strong	.87	-.25	.12	.10
8. honest.....dishonest	-.37	.79	.10	.17
9. delicate.....rugged	.88	-.05	-.18	.20
10. beautiful.....ugly	-.26	.33	.06	.82
11. blameless.....blameworthy	-.69$_a$	.19	-.56	.17
12. tense.....relaxed	.17	-.07	.85	.11
13. loud.....quiet	.38	.45	.06	-.15
14. intact.....damaged	-.77	.21	-.35	.15
15. anxious.....calm	-.10	-.53	.72	.25
16. innocent.....guilty	-.85$_a$	.13	-.36	.19
17. isolated.....connected	.18	-.80	-.06	.08
18. wrong.....right	.77$_a$	.03	.08	-.20
19. responsible.....not responsible	.93$_a$	-.17	.17	.00
20. fast.....slow	.46	.35	.66	.12
21. controlling.....controlled	.55	.00	.61	.18
22. active.....passive	.09	.38	.78	-.23
23. damaged.....intact	.90	.01	.15	.16

Note. The loadings of items 11, 16, 18, and 19 on attribution of blame factor are denoted by $_a$.

Table B.12
Rotated Component Matrix for Four Factor Solution of Semantic Differential Ratings of Mother of Child with Schizophrenia

Item	Component 1	2	3	4
1. sociable.....unsociable	.08	.81	.28	.17
2. large.....small	.18	.77	.43	.22
3. clean.....dirty	.31	.55	.61	.17
4. healthy..... sick	.63	.65	.21	.08
5. good.....bad	.80	.31	.33	.31
6. sad.....happy	-.44	-.21	.84	.09
7. weak.....strong	-.17	-.02	-.37	-.22
8. honest.....dishonest	.25	-.12	.67	.00
9. delicate.....rugged	-.29	-.15	-.05	-.80
10. beautiful.....ugly	.53	.31	.72	-.17
11. blameless.....blameworthy	.87 $_a$	.16	.08	.11
12. tense.....relaxed	-.59	-.46	.58	-.22
13. loud.....quiet	-.05	.68	-.16	.40
14. intact.....damaged	.33	.51	-.05	.33
15. anxious.....calm	-.33	-.50	.30	.66
16. innocent.....guilty	-.86 $_a$	.08	.29	-.16
17. isolated.....connected	-.30	-.76	.33	.31
18. wrong.....right	-.94 $_a$	-.20	-.11	.03
19. responsible.....not responsible	-.81 $_a$	-.31	-.19	.41
20. fast.....slow	-.14	.38	.06	.71
21. controlling.....controlled	.23	.85	-.09	-.07
22. active.....passive	.27	.89	-.28	.03
23. damaged.....intact	-.78	-.11	.26	-.17

Note. The loadings of items 11, 16, 18, and 19 on attribution of blame factor are denoted by $_a$.